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Massachusetts Annual Victim Rights Conference

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Tuesday, April 25, 2000
8:00AM - 4:00PM
The World Trade Center, Boston

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SPONSORS:
Massachusetts Victim and Witness Assistance Board
Massachusetts Office for Victim Assistance
Attorney General Tom Reilly

MOVA/VWAB
1 Ashburton Place, Room 1101
Boston, Massachusetts 02108
Phone (617) 727-5200
Fax (617) 727-6552
E-Mail: MOVA@state.ma.us

MASSACHUSETTS OFFICE FOR VICTIM ASSISTANCE
MOVA
VICTIM & WITNESS ASSISTANCE BOARD

Massachusetts Annual Victim Rights Conference

Tuesday, April 25, 2000
The World Trade Center, Boston

National Crime Victims' Rights Week: April 9-15, 2000

MASSACHUSETTS OFFICE FOR VICTIM ASSISTANCE
MOVA
VICTIM & WITNESS ASSISTANCE BOARD

Massachusetts Victim and Witness Assistance Board
Attorney General Tom Reilly, Chairman
Gerard Downing, District Attorney for Berkshire County
Mary Ellen Doyle, Victim/Public Member
Elizabeth Scheibel, District Attorney for Northwestern District
Evelyn Tobin, Victim/Public Member

Massachusetts Office for Victim Assistance
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Brooke Ely, Family Violence/SAFEPLAN Project Manager
Robert Fleck, Victim Program Specialist
Liam Lowney, Policy Analyst
Rhonda Matthews, Victim Services Coordinator
Larissa Matzek, Training Coordinator
Barbara Pryor, Community Education Coordinator
Jennifer Williams, Intern
Lynne Williams, VOCA Grant Specialist
VOCA Program Manager, VACANT

Massachusetts Annual Victim Rights Conference 2000

CO-SPONSORSING ORGANIZATIONS

- Alpha Resource Center, Inc.
- Arbour Foundation, The Trauma Center
- Beth Israel Deaconess Medical Center, Center for Violence Prevention and Recovery
- Brockton Family and Community Resources, Inc.
- Casa Myrna Vasquez, Inc.
- Charlestown After Murder Program
- Community Advocacy Program of CCHERS
- Criminal History Systems Board, Victim Service Unit
- Daniel A. Larson Foundation
- Domestic Violence Institute, Northeastern University School of Law
- EMERGE
- Executive Office of Elder Affairs
- Executive Office of Public Safety, Programs Division
- HarborCOV, Inc.
- Help for Abused Women and Children
- Holy Family Hospital and Medical Center
- Independence House, Inc.
- Jane Doe, Inc.
- Joey Fournier Victim Services
- Justice For All: Silent No More
- Living After Murder Program of Roxbury Comprehensive Community Health Center
- Louis D. Brown Peace Institute
- Massachusetts Department of Correction, Victim Service Unit
- Massachusetts Department of Youth Services
- Massachusetts District Attorney's Association
- Massachusetts District Attorney's Victim Witness Program Directors
- Massachusetts Parole Board
- Massachusetts Sheriff's Association
- Mother's Against Drunk Driving
- OMEGA, Emotional Support Services, Inc.
- Post Homicide Family Support Program
- Service Net
- Stop Handgun Violence
- Survivors Of Homicide Organized for Change
- The Network for Battered Lesbians and Bisexual Women
- Transition House, Teen Dating Intervention Project
- U.S. Attorney's Office
- Violence Recovery Program
- Women's Protective Services

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Massachusetts Annual Victim Rights Conference

Tuesday, April 25, 2000

The World Trade Center, Boston

Conference Program

8:00-8:45 **Registration, Exhibits, and Breakfast**

9:00-11:30 **Plenary Session**

Welcome: Shelagh Moskow, Executive Director
Massachusetts Office for Victim Assistance

Address: Attorney General Tom Reilly, Chairman
Victim and Witness Assistance Board

Awards Presentation:

Innovations/Public Policy: Gladys Aquino-Gaines
Legislator: Representative David Donnelly
Media: Susan Wornick
Victim Witness Advocate: Marcia Hill
Special Recognition: Curt Rogers
Victim Advocate Service Recognition

Keynote Address: Richard Hoffman, Author of *Half the House*

11:45-1:15 **Concurrent Workshops:**

A. Self-Renewal: For the Days the Dragon Wins

Panelists:

- Priscilla Dass-Brailsford, Coordinator of the Community Crisis Response Team, Central Street Health Center
- Annie Lewis-O'Connor, A Sexual Assault Nurse Examiner
- Edward Harris, Director, Positive Edge
- Lynn Sanford (morning), LICSW, Psychotherapist
- Janet Yassen (afternoon), Coordinator of Crisis Services, Victims of Violence Program

B. The Impact of Victimization on Families

Panelists:

- Diane Litchfield, A survivor of domestic violence
- Liam Lowney, Brother of a homicide victim
- Sharon Simone, A survivor of child sexual and physical abuse
- Bette Spear, Executive Director, OMEGA Emotional Support Services, Inc.

C. The Victim Bill of Rights: Its Past and Future

Panelists:

- Andrea Cabral, Chief of District Courts and Community Prosecutions, Suffolk County District Attorney's Office
- Janet E. Fine, Chief, Victim Witness Assistance Program, Suffolk County District Attorney's Office
- Marcia M. Hill, Director, Victims Service Unit, Massachusetts Parole Board
- Dave Johnson, A father of a child sexual assault survivor

D. Understanding the Biological Basis of Trauma

Panelists:

- Dr. Bessel A. van der Kolk, (morning), Director, The Trauma Center
- Dr. Terence Keane, (afternoon), Chief of Psychiatry Veterans Medical Center

E. Beyond Victimization: Ways of Healing

Panelists:

- Kathy O'Neill Alexander, Director of Education & Outreach, Northwestern District Attorney's Office
- Deb Brunet, A survivor of violent crime
- Robin Casarjian, Executive Director, The Lionheart Foundation
- Richard Hoffman, Author of the book *Half the House*

1:15-2:30 **Lunch** (available on site, on your own)

2:30-4:00 **Afternoon Session**: Workshops Repeated

Victim Rights Conference 2000

Workshop Descriptions

Self-Renewal: For the Days the Dragon Wins

While working in victim services is very rewarding, it can also be a very stressful occupation. Victim service providers are exposed to violence and see the degradation of human beings first hand. There can also be frustration with the pace of change within the system and the fact that injustices are often not remedied. This workshop will explore the various types of stress that can occur in the professional lives of victim service providers. Such stress can range from agitation and anxiety to vicarious traumatization and a re-triggering of one's own victimization. The panel will examine the various kinds of stress, the warning signs of stress, and the long-term effects of stress. The panel will also offer stress-management strategies and suggestions for improving self-care.

The Impact of Victimization on Families

An entire family may be profoundly affected when one of its members is victimized. Although only one family member may directly experience the victimization, other family members may carry varying amounts of pain or other feelings. Family members each react in their own unique ways simply because they care about and are connected to the victim. Families as a whole react differently to victimization depending on whether family members live together or apart, are in contact often or rarely, or feel emotionally close or distant from one another. This workshop will bring together survivors of different types of violence and a clinician specializing in victimization to discuss how and why victimization affects families and to explore strategies for helping families to rebuild and strengthen themselves in the aftermath of violence and tragedy.

Understanding the Biological Bases of Trauma

Psychological trauma has profound effects on biological functioning. Inescapable traumatic experiences cause changes in psychophysiology, neuroendocrine responses and immune function. New research on the brain, such as the recently developed capacity to make detailed images of brain function, has encouraged important advances in our understanding of how trauma affects stress modulation and why traumatic memories can be so entrenched and repetitive. This workshop features clinicians who will discuss the various biological changes that occur in the human body when it experiences psychological trauma. The clinicians will also explain how ordinary memories are stored in contrast to traumatic ones, and discuss how these experiences lead to Post-Traumatic Stress and Dissociative Disorders. Finally, the clinicians will discuss some new treatments for people with PTSD and Dissociative Disorders, such as psychopharmacology, EMDR, and Exposure Therapy.

The Victim Bill of Rights: Its Past and Future

The Victim Bill of Rights was established by law 16 years ago. From the time of its inception, the law has made a remarkable difference in victims' lives, but much of its original vision still has not been realized. What have been the major successes of the Victim Bill of Rights? What have been the challenges and limitations that service providers continue to face in implementing the rights outlined in M.G.L. c. 258B? What has the research for the upcoming *State of the State of Crime Victims in Massachusetts Report* taught us about what changes are needed to strengthen the Victim Bill of Rights and make sure that it is not just a "paper tiger" listing rights? How can we enforce the spirit and letter of the law? Where should we go from here? In this workshop crime victims, victim service providers, advocates, and prosecutors will explore these and other questions about victim rights.

Beyond Victimization: Ways of Healing

Although some victims may never feel truly whole after being victimized by violent crime, many others have found ways to integrate the experience into their lives, to build a closer relationship with others or themselves and to develop inner strength and peace. Some victims have found meaning through political and social activism. Others find comfort in religion, counseling, or creative projects such as writing or painting. This workshop brings together crime victims and victim service professionals to explore some of the different ways that victims find solace and strength in their journey toward healing.

The Commonwealth of Massachusetts

A Proclamation

By His Excellency

GOVERNOR ARGEO PAUL CELLUCCI

2000

WHEREAS: All citizens, including victims, witnesses and their families who suffer in the wake of crime, deserve to be treated with respect, dignity, compassion and justice; and

WHEREAS: For nearly three decades, the victims' rights discipline in the United States has envisioned a nation where violence is an image of the past and where crime victims are habitually able to access supportive services to help them manage the trauma and pain of crime and victimization; and

WHEREAS: Though the rate of the majority of crimes committed steadily decreases, U.S. residents continue to become involved in 31 million criminal victimizations, 8.1 million of which happen to be violent crimes; and

WHEREAS: In an overwhelming effort to protect victims of crimes, over 30,000 federal and state laws have been passed to defend their rights, while thirty-two states have also passed constitutional amendments that provide victims with essential participatory rights throughout the criminal and juvenile justice systems; and

WHEREAS: Each life lost or touched by a senseless act of violence is one too many, and the victims, families and communities affected must be healed, and

WHEREAS: The Massachusetts Office for Victim Assistance will lead the victim rights movement into the next millennium, when the compassionate, just, and equal treatment of crime victims will become the standard throughout the Commonwealth;

NOW, THEREFORE, I, ARGEO PAUL CELLUCCI, Governor of the Commonwealth of Massachusetts, do hereby proclaim April 9th through April 15th, 2000, to be

CRIME VICTIMS' RIGHTS WEEK

and urge all the citizens of the Commonwealth to take cognizance of this event and participate fittingly in its observance

Given at the Executive Chamber in Boston, this twelfth day of April in the year of our Lord two thousand, and of the Independence of the United States of America, the two hundred and twenty-fourth.

Argeo Paul Cellucci

By His Excellency the Governor

ARGEO PAUL CELLUCCI

William Francis Galvin

WILLIAM F. GALVIN
Secretary of the Commonwealth

GOD SAVE THE COMMONWEALTH OF MASSACHUSETTS

Richard Hoffman

Richard Hoffman's writing and public speaking have combined to help raise public awarness around the issue of child sexual assault. He is a survivor of child sexual violence and the author of the book *Half the House*. This compelling memoir of his experience brought forward many other people who were victimized by the same perpetrator and ultimately led to his conviction and incarceration.

His poetry and prose have appeared in *Hudson Review*, *Kansas Quarterly*, *Shenandoah* and other literary journals. Hoffman also teaches at Emerson College and is the Editorial Director for Frontline Publishing Company. He lives with his wife and two children in Cambridge, Massachusetts.

Victim Advocate Service Awards

Twenty Years of Service

Marcia Hill, Massachusetts Parole Board
Berta Hulme, Norfolk County District Attorney's Office

Fifteen Years of Service

Michael Coffey, Suffolk County District Attorney's Office
Barbara Faherty, Plymouth County District Attorney's Office
Jackie Gaw, Hampden County District Attorney's Office
Mary Glavin, Plymouth County District Attorney's Office
LeRoy Gonsalves, Cape and Islands District Attorney's Office
Christine Malone, Essex County District Attorney's Office
Kathy Morrissey, Office of the Attorney General
Elizabeth Schon Vainer, Suffolk County District Attorney's Office
Mary Shogry-Hayer, Berkshire County District Attorney's Office
Michele Stanton, Bristol County District Attorney's Office
Patricia B. Turner, Berkshire County District Attorney's Office

Ten Years of Service

Patrice Provitola, Middlesex District Attorney's Office
Judy Shurtleff, Criminal History Systems Board

A P R I L

Calendar of Events Spring 2000

Victim Rights Observance

VICTIM RIGHTS CONFERENCE

Tuesday, April 25, 2000

This year's statewide Victim Rights Conference is being held at the World Trade Center in Boston on **Tuesday, April 25, from 8:00am – 4:00pm**. Richard Hoffman is this year's keynote speaker. The conference is sponsored by the Massachusetts Office for Victim Assistance, Victim and Witness Assistance Board, Attorney General Tom Reilly and dozens of victim rights and advocacy organizations. Pre-registration is required. For more information, please contact MOVA's conference coordinator, Larissa Matzek, at (617) 727-0138.

3

Third Annual Victim Witness Assistance Clothing and Home Goods Drive

The Suffolk County Victim Witness Program is sponsoring a clothing and home goods drive in honor of Victim Rights' Week. Collection boxes will be located on the 8th and 9th floors at One Bulfinch Place in Boston on **Monday, April 3 – Tuesday, April 25**. Collection boxes will also be located at Dorcester District Court, 510 Washington Street in Dorcester, Roxbury District Court, 85 Warren Street in Roxbury, and West Roxbury District Court, 3710 Washington Street in Jamaica Plain. The goods will be donated to shelters and other programs throughout Suffolk County. For more information, contact Beth Wright, Alicia Cummings, Jen Caldwell or Jackie Lamont at (617) 619-4000.

5

Discussion: Unsolved Murders, The Forgotten Ones

Justice for All, Victims Silent No More, Inc. is sponsoring a group discussion on unsolved murders with survivors and guests on **Wednesday, April 5 from 6:00pm – 7:00pm**, at Cablevision's Roxbury Studio, 300 Warren Street, Washington Park Mall in Roxbury. For more information, please call (617) 445-3208.

Seventh Annual National Conference on Loss and Transition

The Seventh Annual National Conference on Loss and Transition will be held on **Wednesday, April 5 through Friday, April 7** at the Marriot Hotel in Springfield. The annual conference is sponsored by the New England Center for Loss and Transition. This year's keynote speaker is Ted Kennedy, Jr. For more information, please call (203) 458-1734.

APRIL

5

Celebration and Speak Out

A celebration of ten years of progress toward gender equality in the Massachusetts courts and a Speak Out on positive directions for the new millenium will be held on **Wednesday, April 5 from 3:00pm to 6:00pm** at the Federal Reserve Bank, 600 Atlantic Avenue in Boston. For more information, please call (617) 742-8575 ext. 393.

6

Annual Victim Rights Conference: Domestic Violence: Beyond the Basics

The Hampden County District Attorney's Office is sponsoring the Annual Victim Rights Conference, "Domestic Violence: Beyond the Basics." The conference will be held on **Thursday, April 6, from 8:00am – 4:00pm** at the Log Cabin Banquet and Meeting Facility in Holyoke. For more information, please contact Sonia Pagan at (413) 747-1038.

8

In Anne's Spirit

The Anne E. Borghesani Foundation is sponsoring a silent auction and wine reception on **Saturday, April 8 from 6:30pm – 10:30pm** at the Museum of Our National Heritage, 33 Marrett Road, in Lexington. The auction and reception will be followed by coffee and dessert. For more information, please contact The Anne E. Borghesani Foundation, 24 Hastings Road, Lexington, MA 02421.

10

Victim Rights and Services Information Table

The U.S. Attorney's Office is sponsoring a victim rights and services information table for victims of federal crimes at the U.S. Courthouse, 1 Courthouse Way, 2nd floor, in Boston on **Monday, April 10th from 8:00am - 2:00pm**. For more information, please contact Kathleen Griffin at (617) 748-3140.

Domestic Violence Roundtable

The Suffolk County District Attorney's Office is sponsoring a domestic violence roundtable on **Monday, April 10 from 1:00pm – 2:00pm**, at the Charlestown District Court, 3 City Square in Charlestown. The roundtable discussion will focus on the court process. For more information, please call Kelcie Cooke at (617) 725-8720.

11

Open House at Sarah's Place

The Middlesex District Attorney's Office is holding an open house at Sarah's Place on **Tuesday, April 11 from 2:00pm – 4:00pm** at Sarah Pryor's Room, 8th Floor, Middlesex Superior Courthouse, 40 Thorndike Street in Cambridge. Sarah's Place is a suite of rooms providing safety, privacy and a retreat for victims of violence during their involvement with the criminal justice system. For more information, please contact Patrice Provitola at (617) 679-6528.

A P R I L

11

The Yellow Dress

The Victim Services Unit of the Massachusetts Parole Board is sponsoring a production of *The Yellow Dress* presented by Deana's Fund. *The Yellow Dress*, an educational theater program about relationship violence, will be performed on **Tuesday, April 11 at 10:00am** at the Massachusetts Parole Board, 27-43 Wormwood Street in Boston on the 3rd floor. For more information, please contact Lisa Cucurullo or Linda Sweeney at (617) 727-3271.

Jane Doe Rally and Summit

Jane Doe, Inc. will be holding a rally, "Breaking the Silence on Sexual Violence," on the steps of the State House in Boston on **Tuesday, April 11 from 12:00pm – 1:00pm**. Following the rally a summit on "Taking Action on Sexual Violence" will be held in Gardner Auditorium at the State House from **1:00 – 5:00pm**. Advance registration for the summit is required. Interested participants may register online at www.besafe.org

CORI Information and Registration Awareness

Joey Fournier Services is organizing an information booth to raise awareness of Victim Rights Week and the need for Criminal Offender Record Information (CORI) certification by the Criminal History Systems Board. The information booth will be located at the Park Street T station in Boston on **Tuesday, April 11 from 11:00am – 1:30pm**. For more information, please contact Barbara Palazzo at (978) 837-5474.

12

S.E.N.I.O.R.S. Aging Gracefully Safety Series

The monthly meeting of the Aging Gracefully group of the S.E.N.I.O.R.S. project will focus on safety inside and outside of the home. The meeting will focus on techniques and strategies for protection and prevention. The safety series will be held at Roxbury Multi-Service Center, Inc. at 317 Blue Hill Avenue in Dorcester on **Wednesday, April 12 from 10:30am - 12 noon**. For more information, please contact Sandra Hughes at (617) 541-5417.

Employers Against Domestic Violence Presents "Tough Guise"

EADV will present "Tough Guise," a documentary and discussion about witnessing and responding to domestic violence. Tough Guise will be presented on **Wednesday, April 12 from 12:00pm – 2:00pm** at the JFK Federal Building, Room E275-B, Government Center, in Boston. The program fee is $10, however the fee may be waived. For more information, please contact Traci Swartz at (617) 348-4970.

13

Same-Sex Domestic Violence Workshop for Medical Providers

The Violence Recovery Program at the Fenway Community Health Center is sponsoring a workshop for doctors, nurses, medical administrators and other medical providers to discuss strategies for addressing same-sex domestic violence in their practice. The workshop will be held at the Fenway Community Health Center on **Thursday, April 13 from 9:00am – 10:30am**. Please RSVP to Emily Pitt at (617) 927-6269. This is a free workshop.

APRIL

14

Louis D. Brown Fellows Peace Award Ceremony

The awards are given to 30 high school students for their demonstrated understanding of peace. Boston's *Book of Peace*, Volume IV will also be released at the ceremony. The event is located at the Hynes Convention Center in Boston on **Friday, April 14 from 5:30pm – 9:00pm**. The event is free of charge. For more information, please contact Lynda McNally at (617) 825-1917.

19

Boston Municipal Court Roundtable

The Suffolk District Attorney's Office is sponsoring a Boston Municipal Court Roundtable. Mark Green from EMERGE will be the guest speaker. He will speak on the difference between batterer's intervention programs and anger management courses. The roundtable will be held on **Wednesday, April 19 from 1:00pm – 2:00pm** at the Boston Municipal Courthouse, Pemberton Square, Room 413 in Boston. For more information, please call Winnie Yam at (617) 619-4050.

20

The Chelsea Domestic Violence Roundtable

The Suffolk District Attorney's Office is sponsoring The Chelsea Domestic Violence Roundtable on **Thursday, April 20 from 2:00pm – 3:00pm** at the Chelsea Courthouse, 120 Broadway in Chelsea. For more information, please contact Lia Chuilli at (617) 884-2200.

24

First Annual Candlelight Vigil

Project Reach is sponsoring a vigil in remembrance of "our loved ones." The vigil will be held at the Cape Cod Canal, at the Herring Run, on **Monday, April 24 at 6:30pm**. (The Herring Run is located between the Bourne and Sagamore Bridges.) For more information, please call (508) 996-3147 ext. 153.

26

7th Annual National Bereavement Teleconference

The National Center for Death Education is sponsoring its annual teleconference on bereavement at Mount Ida College on **Wednesday, April 26 from 1:30pm - 4:00pm**. For more information, please contact Judith Harding at (617) 928-4649.

Clothesline Project

Greenfield Community College is sponsoring a clothesline project on **Wednesday, April 26 and Thursday, April 27 from 10:00am – 7:00pm** on the South Lawn at Greenfield Community College. The clothesline is a display of T-shirts that have been painted by women and children who are survivors of domestic violence. For more information, please contact Donna Larson at (413) 775-1430.

APRIL

26

Victim Rights and Services Information Table

The Suffolk County District Attorney's Office is sponsoring a Victim Rights and Services Information Table on **Wednesday, April 26 from 11:00am – 12:30pm** at Madison Park High School, 75 New Dudley Street in Roxbury. For more information, please call Jose Solis at (617) 635-8970.

30

Walk for HAWC 2000

Help for Abused Women and Children (HAWC) is sponsoring a five-mile walk on **Sunday, April 30th starting at 2pm**, through historic Salem to raise funds for HAWC. HAWC provides free, comprehensive services to abused women across the North Shore. For "Walk" information, call (978) 744-8552 ext. 11.

10th Annual Walk for Women's Lives

This event is sponsored by the Acton and Lexington chapters of NOW, the Lincoln and Acton area League of Women Voters, and the Lahey Clinic to help put a stop to violence against women. This event is a 3-mile walk starting at Concord Carlisle High School. The walk takes place on **Sunday, April 30th and begins at 12:00pm**. For more information, call (978) 937-5777.

Chris Maki Violence Awareness Walk

The Chris Maki Memorial Fund is sponsoring the annual Chris Maki Violence Awareness Walk. The walk will begin at St. Boniface Church in Lunenburg on **Sunday, April 30th at 1:00pm** and is in memory of Christopher Maki, a victim of homicide. For more information, call Ray and Jane Maki at (978) 345-1870.

9th Annual Walk Against Violence

This 4-mile Walk Against Violence will start at the Market Landing Park in Newburyport on **Sunday, April 30 at 1:30pm**. All proceeds will go to the Women's Crisis Center to provide free crisis intervention services to victims of domestic violence. Registration will be held from 11:00am – 1:30pm. For more information and pre-registration, please call (978) 465-7158 ext. 25.

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Calendar of Events
Spring 2000

2

Social Change Theater

The Coalition for a Safe Community in cooperation with Social Change Theater is presenting skits and discussion on emotional abuse and harassment. The performance will be held on **Tuesday, May 2 at 7:00pm** at GCTV studio, 393 Main Street, 3rd floor, in Greenfield. For more information, please contact Abbie Jenks at (413) 775-1127. This event is part of Franklin County's Week of Awareness.

Exploring the Relationship Between Violence in America and Masculinity

This event will feature a showing of the film "Tough Guise" followed by an interactive discussion on strategies for addressing male violence moderated by Kathy Alexander. The event will be held on **Tuesday, May 2 from 6:30pm – 8:30pm** at Mohawk Regional School Auditorium, Rt. 112, in Buckland. This workshop is sponsored by the Mohawk Trail Regional School Comprehensive Health Program and the DOE Sage and Drug-Free Discretionary Program. For more information, please contact Karyn Skiathtis at (413) 625-0192, ext. 40. This event is part of Franklin County's Week of Awareness.

3

Discussion: Bullying and Battering

Lundy Bancroft will speak on bullying, explore its connection to domestic violence and discuss prevention strategies. He will present an analysis of the problem and suggestions for solutions. Free pizza and childcare will be available. The event will be held on **Wednesday, May 3 from 6:30pm – 9:00pm** at the Athol Town Hall, 584 Main Street, in Athol. The Violence Prevention Task Force of the North Quabbin Community Coalition, and Clinical and Support Options of Athol are sponsoring this workshop. For more information, please contact Karen Fogliatty at (978) 249-9926. This event is part of Franklin County's Week of Awareness.

4

Take Back Our Lives March and Rally

This event commemorates women killed by domestic violence and empowers survivors to "take back their lives." The event will feature speakers, music, and performances, open microphone time and the unveiling of a commemorative flag. The rally will be held on **Thursday, May 4 from 6:00pm – 8:00pm**, followed by the march from **8:00pm to 9:00pm** at Greenfield Energy Park, Miles Street, in Greenfield. The rally and march are sponsored by the New England Learning Center for Women in Transition (NELCWIT). For more information, please contact Sharon Alpert at (413) 772-0871, ext. 31 or Aixa Quiros at (413) 772-0871, ext. 12. This event is part of Franklin County's Week of Awareness.

MAY

4
Elder Protection: What You Should Know About Elder Abuse
This program will explore the topic of elder abuse. Speakers are from the Northwestern District Attorney's Office and Franklin Company Home Care. This event will be held on **Thursday, May 4 at 5:30pm** at St. Kaziemerz Hall, 197 Avenue A, in Montague. The Montague/Gill Triad sponsors the event. The cost for tickets is $2.00 and the event is open to Montague and Gill residents. For more information, please call Ray Zukowski at (413) 863-8911 or Bunny Caldwell at (413) 863-9357. This event is part of Franklin County's Week of Awareness.

5
Employers Against Domestic Violence Luncheon
Speakers from EADV will discuss the topic of domestic violence in the workplace. The luncheon will be held on **Friday, May 5 from 12:30pm – 2:30pm** at Yankee Candle Company, Routes 5 and 10, in South Deerfield. The luncheon is sponsored by the Northwestern District Attorney's Office and Yankee Candle Company. The cost for the luncheon is $10.00. Please RSVP by April 28. For more information, please call B.J. Vanasse at (413) 774-3186. This event is part of Franklin County's Week of Awareness.

6
Annual Gospel Concert: "Celebration of Praise"
The Living After Murder Program (L.A.M.P.) is sponsoring this gospel concert in honor of survivors and in memory of murdered loved ones. The event will be held on **Saturday, May 6 at 6:00pm**. For more information, please contact Christine Caines-Dodson at (617) 541-3790, ext. 719.

13
Garden of Remembrance Planting
This flower garden will be dedicated to those in Worcester County who have lost a loved one to homicide. The garden planting will take place on **Saturday, May 13 from 11:00am – 2:00pm** in Lincoln Square in Worcester. Please come and plant a flower in memory of a lost loved one. All supplies will be provided. A barbecue and refreshments will follow. This event is sponsored by the After Homicide Program of the Worcester Youth Guidance Center. For more information, please contact Amy Hurley at (508) 791-3261.

14
The Melrose Run for Women
This 3.5-mile race will be held on **Sunday, May 14 at 9:00am**. Registration for the race is required. All proceeds will benefit the Melrose Alliance Against Violence (MAAV). For more information, call Linda at (781) 322-2075 or visit www.melroserunningclub.com

MAY

14

Fourth Annual Mother's Walk for Peace

The Louis D. Brown Peace Institute is sponsoring a 3.6-mile walk that will start and end in Fields Corner in Dorcester. The walk will take place on **Sunday, May 14 at 8:00am**. Registration begins at 6:00am. The walk will bring together people from around the state to promote peace, to highlight the need for parents to work to protect each other's children, and to remember children who have been lost to violence. For more information, please contact Darla Jackson at (617) 825-1917.

Million Mom March

Stop Handgun Violence is organizing groups from Massachusetts to participate in the Million Mom March in Washington D.C. on **Sunday, May 14**. If you are interested in chartering a bus for your church, temple, school, family, town, etc. please contact Elizabeth Miles at 1-877-SAFE ARMS. The cost for transportation is $45.00 per person roundtrip.

15

Domestic Violence Education Program

The Melrose Alliance Against Violence (MAAV) is offering an innovative domestic violence education and screening program to help abused women. The program will educate hairdressers and manicurists about the dynamics of domestic violence, recognizing the signs of abuse and guidance on how to discuss the topic with clients who may be potential victims. Salons are asked to send one representative to the training that can take back the information to share with other salon employees. The event will be held on **Monday, May 15 from 9:30am – 11:00am** at Pauli's Restaurant in Melrose. For more information, or to register please call Rebecca Mooney at (781) 662-2010.

21

Peace Day 2000

Peace Day 2000 is held in remembrance of "Meiko" Hill. Peace Day will be held on **Sunday, May 21 at 2:00pm** in O'Day Park, South End in Boston. For more information, please call (617) 287-2434.

Section A:
Self-Renewal: For the Days the Dragon Wins

Section A: Self-Renewal: For the Days the Dragon Wins

Panelists:

Priscilla Dass-Brailsford
Coordinator of the Community Crisis Response Team
Central Street Health Center
Somerville, MA 02143
(617) 498-1180

Annie Lewis-O'Connor
Program Manager for Maternal and Health Services
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210-1120
(617) 478-7169

Edward Harris
Director
Positive Edge
795 Massachusetts Avenue
Cambridge, MA 02139
(617) 349-4209

Lynn Sanford (morning)
LICSW, Psychotherapist
Newton, MA 02459
(617) 527-9793

Janet Yassen (afternoon)
Coordinator of Crisis Services
Victims of Violence Program
Central Street Health Center
Somerville, MA 02143
(617) 945-5676

Coordinator: **Barbara Pryor**

WHEN HELPING HURTS

VICARIOUS TRAUMATIZATION

Barbra Williams Cosentino, RN, CSW

I AM LYING ON A MASSAGE TABLE under a blue sky, the aroma of pinon trees scenting the air, the sweet trill of songbirds echoing in my ears. A massage therapist is touching my body - kneading, stroking, twisting. She rolls me on my back and begins to press firmly on my upper body, extending the pressure down my arms, her strokes long and smooth. Suddenly, I am sobbing, feeling something release inside me, viscerally aware for the first time of just how tense and exhausted I've been, of how my arms and shoulders have been aching, of the stress I've been under trying to deal with the tragedies of my patients' lives. I now realize that carrying the weight of my patients' problems around with me has been depleting my physical and emotional energy.

Healthcare workers, law enforcement officers, firefighters, psychotherapists, emergency room personnel and other members of the helping professions are prone to a disorder known as vicarious traumatization, also referred to as secondary traumatic stress, compassion fatigue, or burnout. Beth Hudnall Stamm, PhD, of the National Center for Post-Traumatic Stress Disorders in Vermont says, "The great controversy about induced trauma is not 'Can it happen' but 'What shall we call it?'"[1]

The above terms have been used, often interchangeably, to explain a constellation of symptoms often seen in helpers who are continually exposed to the raw, intensely painful emotions of clients who have witnessed or survived traumatic life events such as sexual assault, mass violence, or a physical disaster, as well as in those who work with patients suffering from physical or emotional illnesses or serious injuries.

Charles R. Figley, PhD, whose groundbreaking research with Vietnam veterans led to the formulation of Post Traumatic Stress Disorder (PTSD) as a clinical entity, says "Compassion fatigue - a term originally used in 1982 in association with observations about burnout among nurses - is a type of burnout, a collection of symptoms associated with working with the suffering, causing feelings of being filled up and overwhelmed, wrung out from all that suffering. In effect, we become traumatized secondarily - we weren't the one in harm's way, but we work with people who were, and we become, in some ways, infected by their trauma."[2] This can create a sense of vulnerability and fragility in the healthcare professional, awakening old memories and reactivating pain and sadness about previous losses or traumas experienced in their own lives.

The experience of vicarious traumatization is a developing process, not a solitary event, and can lead to strong emotional reactions of grief, rage, frustration, or profound feelings of loss and despair. Emotional numbing, repression, displacement, cynicism and isolation of feelings may be used as defense mechanisms to ward off unbearable feelings of pain. Physical or emotional symptoms may occur, similar to those experienced by people with PTSD, and may include –

- cardiovascular, gastrointestinal, musculoskeletal and neurologic symptoms: i.e. increased heart rate and blood pressure, fatigue, appetite disturbances, ulcers, headaches.
- psychological symptoms such as anger, constricted affect, diminished interest, cynicism, nightmares, intrusive thoughts (flashbacks) numbing of responsiveness to environment, social withdrawal, substance abuse or dependence, and spiritual distress.

- decreased coping abilities/lowered stress tolerance, manifested by high levels of anxiety, feeling tense much of the time, feelings of "going crazy," feeling extremely vulnerable and fragile
- cognitive-perceptual changes such as memory impairment, difficulty learning, and poor concentration
- altered role-relationship patterns that include inability to maintain relationships with family or significant others, disillusionment with job, inability to sustain job performance, diminished ability to care about others, feeling alone and uninvolved with environment

Prevention and Treatment of Secondary Traumatization

Lisa Rattenni, RN, MSN, CNA, associate director of patient care services at the New York Presbyterian Hospital - Westchester Division, the Behavioral Health Division of New York Presbyterian Hospital, says, "Education is a key factor in preventing burnout and in keeping it at bay. It's an old expression, but knowledge truly *is* power." Rattenni says that her hospital strives to create a positive environment by having a number of programs in place to provide ongoing support to staff while fostering a sense of autonomy and job satisfaction. These include individual and group supervision with a nurse manager or senior staff nurse, weekly and monthly staff meetings, and educational seminars on dealing with difficult patients, since working in a psychiatric hospital with severely, persistently mentally ill patients can bring up feelings of hopelessness, helplessness, anxiety and frustration. Nurse managers are trained to recognize early signs of burnout such as increased negativity, anger, complaints about the work environment, demanding behaviors, or the frequent use of sick-days. Managers are also encouraged to be flexible and supportive by arranging work schedules so staff has "chunks of time" off for rest, replenishment, and recuperation.

Rattenni points out that "when nurses are unhappy or overwhelmed due to work stresses, it creeps into all other aspects of their lives. Supportive management, the availability of employee assistance programs (EAPs), the opportunity to vent, and the provision of a positive work environment are crucially important, but in the end we all need to find ways to care for ourselves, to use meditation, exercise, relaxation techniques, psychotherapy, or whatever works. Ultimately, we are each responsible for our own health and well-being."

"Processing" or "debriefing" after an upsetting incident, done on a larger scale for healthcare personnel, rescue workers, law enforcement officers and others who are involved in working with survivors of mass disasters, is an important tool in the prevention of secondary traumatization. Arlie Kalayjian, RNC, EdD, DDL, BCETS, BCECR, a fellow of the American Academy of Experts in Traumatic Stress, who co-chairs the Global Institute for Nursing and Health, has conducted mental health intervention programs for nurses and other rescue workers in Japan, Armenia, Southern Florida, and most recently, in Turkey after its devastating August earthquake. Kalayjian uses a six-step model that can be adapted to many situations. The helper uses the model to:

- assess the level of vicarious traumatization
- encourage expression of feelings
- validate and legitimize the feelings that are expressed
- assist in the process of making sense of the experience and helping people to discover lessons, positive associations, or personal or spiritual meaning in the tragedy
- provide didactic information
- encourage use of letting-go and self-care techniques (e.g. yoga, massage, Reiki, diaphragmatic breathing, creative imagery)

Kalayjian emphasizes the importance of incorporating spiritual elements in the prevention and treatment of vicarious traumatization, since large-scale disasters can engender feelings of hopelessness, emptiness, and loss of faith.

Nurses who work with Alzheimer patients, rape victims, burn patients, and other difficult populations can also benefit from this model. For example, Kalayjian once consulted at a state-subsidized detoxification center in the Bowery where the patients were "homeless, helpless and resourceless." The chronic nature of their problems caused many staff members to feel burnt-out, displaying irritability, inability to stay focused, depression, increased incidence of somatization, and tardiness and absence from work. Kalayjian ran a series of workshops during which the staff was encouraged to vent feelings of frustration and their sense of hopelessness in reversing the revolving-door syndrome. Staff morale greatly improved as a result of being able to express concerns and having them validated in a safe and supportive setting.

While caring for those who have been hurt, traumatized, or injured can be draining, it is also incredibly gratifying to touch a life: to hold a heart in your hands at a moment of extreme vulnerability and help it heal; to be there for someone who has experienced great trauma or pain until he or she can "become strong at the broken places." For many of us, that is the ultimate satisfaction and joy in being a nurse.

Barbara Williams Cosentino, RN, CSN, is a frequent contributor to Nursing Spectrum.

TAKING CARE OF OURSELVES

Why is it important that we take care of ourselves?

When we begin working with victims of domestic violence and sexual assault friends and family members will often ask us:

- How do you do it?
- How do you cope with the pain and suffering of others day in and day out?
- How do you "turn off" your work when you go home?
- Isn't it depressing?

This work can be extremely rewarding, but remember…

- As we listen, support and validate the experiences and feelings of others we take in some of their pain.
- We might realize that Domestic Violence and Sexual Assault and extensive and infinite.
- Persons whose work has consumed their thoughts, workday or personal life by taking in the experiences and emotions of victims may develop what's called vicarious trauma.

What is vicarious trauma?

"Transformation of the helper's inner experience, resulting form empathetic engagement with client's trauma material" If your work involved listening, with empathy and care, to the stories of people who have been traumatized, with the intention to help, you are vulnerable to VT. This is not something clients do to us; it is the result of opening our hearts, caring and facing the reality of human trauma. *Karen Castelbaum*

What are some other phrases to describe vicarious trauma?

- Compassion fatigue
- Countertransference
- Secondary traumatic stress
- Empathic strain
- Secondary victimization
- Burnout
- Chronic stress

What are the symptoms of vicarious trauma?

PHYSICAL SYMPTOMS

- Appetite changes
- Headaches
- Tension
- Fatigue
- Insomnia
- Colds
- Muscle aches
- Digestive upsets
- Teeth grinding
- Rash
- Lower back pain
- Tension at the base of neck
- Lowered sex drive
- Increase alcohol, drug or tobacco use

MENTAL SYMPTOMS

- Forgetfulness
- Dulled senses
- Poor concentration
- Negative attitude
- Confusion
- Negative self-talk
- Can't get "pictures" out of your mind
- PTSD symptomology

EMOTIONAL SYMPTOMS

- Anxiety
- Frustration
- Nightmares
- Irritability
- Depression
- Worrying
- Discouragement
- Joylessness
- Isolation
- Loneliness
- Lashing out
- No time/energy for one's self
- Disconnection from loved ones
- Increased sensitivity to violence
- Cynicism
- Generalized despair/hopelessness

SPIRITUAL SYMPTOMS

- Emptiness
- Loss of meaning
- Loss of direction
- Apathy
- Cynicism
- Social withdrawal

What are the characteristics of the stages of vicarious trauma?

FIRST

- High energy
- Satisfaction with work
- Using more energy than you realize

SECOND

- Energy drain is visible
- Inefficiency in work
- Fatigue
- Procrastination

THIRD

- Chronic exhaustion
- Physical illness

FOURTH

- Loss of enthusiasm
- Attitude of indifference to others' needs
- Feelings of failure

FIFTH

- Loss of functioning
- Leaving job
- Using drugs or alcohol
- Seeking counseling

THIS IS NOT A TEST! TRY TO BE HONEST WITH YOURSELF BECAUSE ONLY YOU WILL SEE WHAT YOU HAVE DECIDED. IT'S SELF-SCORING. THERE ARE NO RIGHT OR WRONG ANSWERS. GIVE YOUR PERSONAL OPINION. IF YOU AGREE WITH THE STATEMENT AND THINK THAT IT'S TRUE FOR YOU, WRITE YES ON THE LINE NEXT TO THE NUMBER. IF YOU DISAGREE WITH THE STATEMENT AND THINK THAT IT'S NOT TRUE FOR YOU, WRITE NO ON THE LINE NEXT TO THE NUMBER.

1_____ It seems impossible to have relaxed. pleasant times with my family; my job eats by all my energy.

2_____ When I make plans, I usually can carry them out.

3_____ When daughters or sons become adolescents, parents lose most of the influence they can exert on their behavior.

4_____ I should be able to help most people with whom I work (my clients) take some control over their lives.

5_____ My salary just isn't enough to make ends meet and I can't do anything about it right now.

6_____ I can have an impact on the decisions made by upper level administration/management of the agency where I work.

7_____ I don't plan too far ahead: many things turn out to be a matter of good or bad luck anyhow.

8_____ I might not be able to control what happens to me, but I can control what it does to me; that is, I do have some real control over my emotional reactions.

9_____ It's practically impossible to change the stereotypic ideas that many people have about developmental disabilities, people on welfare, the elderly, minorities, women and people with psychological problems.

10_____ If I work hard enough to accomplish something, I can usually make it happen.

A) Look at the odd numbered items. If there is a YES next to that number, circle the number in the vertical column on the left-hand side of the page.

B) Look at the even numbered items. If there is a NO next to that number, circle the number in the vertical column on the left-hand side of the page.

C) Add up each of the circles you have on the paper: _____ Circle the appropriate number on the horizontal line below.

CAN I MAKE A DIFFERENCE?

YES 0 1 2 3 4 5 6 7 8 9 10 NO

I CAN MAKE A DIFFERENCE SOMETIMES
WE MAY NOT HAVE CONTROL OVER THE BEHAVIOR OF OFFENDERS OR A VICTIM'S SAFETY
KNOW WHICH SITUATIONS YOU CAN CONTROL AND THOSE THAT YOU CANNOT

What can we do to prevent vicarious trauma?

1. Acknowledge that it may affect you and know the warning signs of VT
2. Examine your support system
   a. Do you have contact with others who work with victims? Do you regularly receive peer consultation and or supervision?
   b. Do you have a regular on-going safe environment to share painful reactions, receive support and maintain help?
3. Be clear about goals and boundaries
   a. Are you able to say no to excessive demands placed on you by clients?
   b. Are you able to say no to unreasonable requests from staff or volunteers?
4. Address your self care outside of and during work
   - Get organized
   - Take breaks
   - Rehearse
   - Do it now
   - Know your limits
   - Learn to say "no"
   - Change attitudes
   - Schedule your stress
   - Treat your body right
   - Positive self-talk
   - Take charge
   - Exercise
   - Have internal releases
   - Distract your mind

)()()()

How Do You Handle Stress?

EXERCISE-RELATED

Walking
Working-out
Running
Swimming
Bicycling
Hiking
Playing volleyball
Rollerblading
Yoga
Tai chi
Dancing
Playing tennis

INTERNAL RELEASES

Focusing on letting go
Breathing deeply
Thinking positively
Meditating
Counting backwards
Active relaxation
Spending quiet time alone
Setting limits
Walking away from stressful situation

WITH SOMEONE'S HELP...

Getting a massage
Attending support group/AA meetings
Going to therapy
Snuggling with partner
Playing with pets
Talking with friends/family
Making dates with friends
Sharing feelings

TO DISTRACT YOUR MIND...

Journaling
Gardening
Knitting
Cleaning
Cooking/baking
Eating
Drawing/painting/crafts
Driving
Making lists and prioritizing
Singing
Making music (playing an instrument)
Screaming
Reading
Being silly/unpredictable
Getting mindless tasks completed

JUST PLAIN TAKE A BREAK...

Getting outside
Sitting by the lake/ocean
Laying in a hammock
Looking out the window
Watching t.v./movie
Fixing a cup of tea
Taking a bath
Going on vacation
Taking a REAL lunch break
Listening to nature
Browsing a bookstore/card store
Listening to music

This list was compiled by a number of advocates and staff members working in crisis centers in NH. Thank you for your feedback!

Created by Julie LaSelva Person, MSW

TAKING CARE OF OURSELVES

Restore the person you are

This activity comes from the book *The Artist's Way* by Julie Cameron (1992). Her description of the activity is as follows:

> "When you complete the following phrases, you may feel strong emotions as you retrieve memories and misplaced fragments of yourself. Allow yourself to free-associate for a sentence or so with each phrase." (p. 73)

1. My favorite childhood toy was...
2. My favorite childhood game was...
3. The best movie I ever saw as a kid was...
4. I don't do it much but I enjoy...
5. If I could lighten up a little, I'd let myself...
6. If it weren't too late I'd...
7. My favorite musical instrument is...
8. The amount of money I spend on entertainment for myself each month is...
9. If I weren't so stingy with myself I'd buy...
10. Taking time out for myself is...
11. I'm afraid if I start dreaming...
12. I secretly enjoy reading...
13. If it didn't sound so crazy, I'd write or make a...
14. Learning to trust myself is probably...
15. My most cheer-me-up music is...
16. My favorite way to dress is...

YOU HAVE JUST CREATED IDEAS FOR PERSONAL SELF-CARE.
ALLOW YOURSELF TIME TO DO SOME OF THESE THINGS!

9

Preventing Secondary Traumatic Stress Disorder

JANET YASSEN

Appearing in: C. Figley; Compassion Fatigue: Coping with secondary traumatic stress Disorder in those who treat the traumatized, Brunner / Mazel; 1995

In order to prevent Secondary Traumatic Stress Disorder (STSD) we must first understand what Secondary Traumatic Stress (STS) is and second, what prevention is. Other chapters in this volume describe the impact of traumatic experiences on individuals who have provided care for survivors of medical emergencies, disasters, the Holocaust of World War II, torture, political repression, rape, incest, physical violence, and war. The understanding of this impact is the foundation underlying the development of a model for prevention of STSD.

This chapter presents an understanding of the concept of prevention and offers an ecological model as a framework for planning for the impact of STS. It is based on the premise that STS in itself cannot be prevented since it is a normal and universal response to abnormal (violence induced) or unusual events (disasters). The enduring or negative effects of this response, however, can be prevented from developing into a disorder (STSD). This chapter emphasizes the various components of a

Editor's Note: This chapter focuses on the prevention of secondary traumatic stress disorder (STSD). In conceptualizing prevention and prevention planning, Yassen introduces an ecological perspective to assist professionals in developing treatment plans that include recognition of the secondary impact of traumatic stressors. Tables and illustrations assist the reader in understanding and appreciating the many factors associated with preventing STS from developing into a disorder.

comprehensive prevention program including the individual and environmental aspects of self-care. It assumes that unless we prepare, plan, or attend to the effects of STS, we can cause harm to ourselves, to those who are close to us, or to those who are in our professional care.

The second section of this chapter discusses implementation of a prevention plan. It identifies factors that influence successful prevention planning and makes suggestions for combatting resistance to prevention planning. It is through the creation of an ecological model that stresses the interaction of the personal and environmental influences of prevention that human healing and growth in the face of trauma in enhanced. It is only in this context that the prevention of the deleterious effects of STS can be assured.

Although the primary focus of this chapter is on professional caregivers (including those who provide care in a volunteer capacity), the information provided is also relevant to those who have been indirectly affected by victimization in their personal lives through the victimization of friends, neighbors, community members, significant others, and so on.

Overall, the management of STS and preventing it from developing into disorder means acknowledging its existence and preparing for it. Simply put, the management of STS is developing a lifestyle and skills that will provide a foundation for dealing with the various levels of impact. This foundation will provide the optimum conditions for the prevention of STSD.

UNDERSTANDING PREVENTION

Conceptualization

The concept of prevention in mental health is drawn from the fields of public health and medicine. The public health field studies entire populations and identifies the spread of disease symptoms and the conditions that promote the disease. The medical model of illness focuses on individual symptoms, diagnosis, and treatment. The integration of these two models forms the basis for a mental health prevention model, which assumes that the psychological and social diseases involve both the individual and society, and that the prevention of the deleterious effects and the spread of the diseases must be addressed at various levels (Heller & Monahan, 1977).

Davis and Brody (1979) categorize prevention as: primary, secondary, or tertiary. Broadly stated, primary prevention deals with the underlying social causes of a problem, secondary prevention emphasizes activities

that could reduce the risk of violence or provide preparation to face its impact should it occur, and tertiary prevention focuses on intervention in the aftermath of violence in the form of crisis intervention. Figure 1 illustrates this multidimensional view and the expected results of primary, secondary, and tertiary prevention. This multifaceted approach to prevention of mental health problems has also been described as an ecological approach (Harvey, 1995). It is this ecological approach that is offered here as a practical guide for preventing individual secondary traumatic stress (STS).

The Ecological Approach

Prevention in mental health combines the understanding of the psychological and social impact of disease with the concepts pf primary, secondary, and tertiary prevention. An ecological model draws its view from science concerning the interrelationship of organisms and their environment. This approach is the basis upon which the fields of social work and community psychology are founded. Community psycholo-

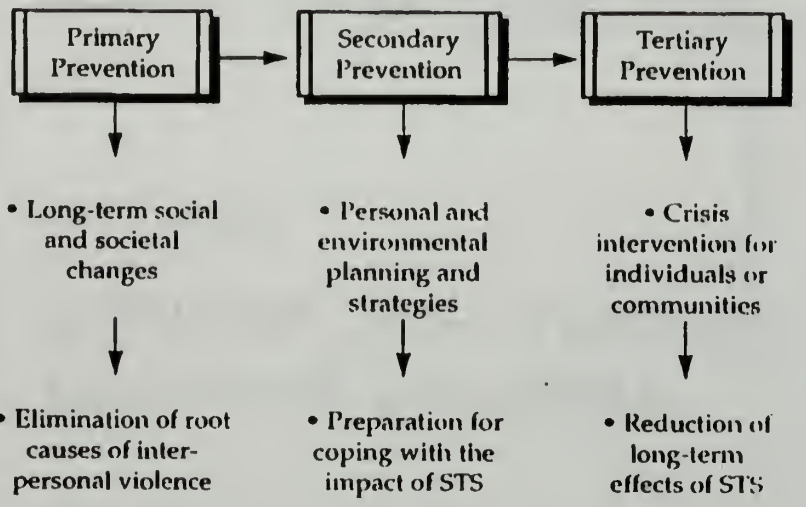
Primary Prevention
Secondary Prevention
Tertiary Prevention
• Long-term social and societal changes
• Personal and environmental planning and strategies
• Crisis intervention for individuals or communities
• Elimination of root causes of inter-personal violence
• Preparation for coping with the impact of STS
• Reduction of long-term effects of STS

Figure 1. Multidimensional framework for preventing STS

(Based on Davis, L. & E. Brody in *Rape and Older Women*, U.S. Dept. of Health, Education, & Welfare, NIMH, 1979, p. 46. Figure 2: Prevention of Rape—Overview of Simultaneous Activities)

gist James Kelly (1977) stresses the interdependence of persons and social settings. This model is based on three assumptions:

1. Physical, social, and psychological environments affect personal behavior.
2. Personal adaptations to environmental conditions facilitate growth and development.
3. Community health is determined by energy flow and the cycling of resources.

There is evidence that while individual adaptation is important (Figley, Mackey, & Meshad, 1991; Flannery, 1990; Lazarus & Folkman, 1984; Medeiros & Prochaska, 1988; O'Rear, 1992), individual coping strategies alone do not alleviate the strain caused by job stress (Shinn, Rosario, Morch, & Chestnut, 1984; Pearlin & Schooler, 1978; Cherniss, 1980). Furthermore, individual adaptation has an important social component that serves as a buffer against disease and stress, and is also a mediator of healing and recovery from the effects of STS (Caplan, 1972; Etzion, 1984; Flannery, Fulton, Tausch, & DeLoffi, 1991; Koss & Harvey, 1991; McCann & Pearlman, 1990). Harvey (1995) applies an ecological perspective to recovery in the aftermath of sexual trauma. She reports that community values and resources have a direct correlation with positive recovery outcome. The application of an ecological approach to the prevention of STS that combines individual and environmental interventions is consistent with these findings.

Several programs are already in existence that address some of the effects of STS on individuals. They include psychodrama groups (Thacker, 1984); models for debriefing debriefers (Armstrong, O'Callahan, & Marmar, 1991; Mitchell, 1983; Talbot, 1990; Talbot, Manton, & Dunn, 1992; U.S. Department of Health and Human Services, 1988); and opportunities to share clinical material (Herman, 1992; McCann & Pearlman, 1990; O'Rear, 1992). They concur with Flannery's four-step approach to stress reduction (1987, 1990), which includes personal control, task involvement, lifestyle choices, and social supports. However, many of these programs do not always explicitly incorporate an ecological approach and thus are limited in preventing long-term effects of STS.

One model that meets all of the criteria of the Kelly approach to ecological prevention is the Community Crisis Response Team (CCRT) of the Cambridge (Mass.) Hospital Victims of Violence Program. The CCRT integrates the prevention of STS in personal providers, as well as in professional caregivers. It is unique because the team itself parallels

the services that it provides for others. Composed of three part-time staff members and a group of volunteers representing more than 40 agencies and various professional disciplines, the CCRT offers crisis intervention to communities that are affected by violence—including schools, church groups, cohorts of friends, staffs, and neighborhoods. Team members can furnish a range of services, from workshops and consultations to debriefing meetings. The CCRT is based on a community empowerment model that stresses Kelly's interdependence of person and environment. Through its group debriefing meetings, it models the importance of social support as the basis of healing in the aftermath of violence, and it provides information to direct victims, as well as to secondary victims, regarding the impact of trauma and effective strategies to cope with it. It serves as a resource for referrals for people who may need additional individual counseling support, either from a resource in their own community or through services at the Victims of Violence Program. The CCRT is an active participant in city and state wide violence-prevention initiatives. Its services are free, and thus it is a resource that is accessible to all.

For the pairs of volunteers who participate in the community interventions, there are planning meetings, as well as debriefing meetings after the interventions. This allows the facilitators of an intervention to plan for as well as process the STS that they may experience as a result of the crisis response. There are also monthly meetings of the entire team, which can include a further sharing of STS responses or may involve learning a new skill, sharing resources, or developing team cohesiveness. The significance of the CCRT model also lies in the way it models for itself the ecological approach to the prevention of STS in its focus on the physical, social, and psychological aspects of the individuals and communities that it assists.

The CCRT illustrates incorporation of the primary, secondary, and tertiary prevention paradigm as illustrated in Figure 1. Specifically, it incorporates the following prevention concepts.

1. Primary prevention. Workshops, antiviolence campaigns, coalition-building, and community involvement address the root causes of violence.

2. Secondary prevention. Debriefing meetings and educational activities assist participants in preparing and planning for the potential impact of trauma.

3. Tertiary prevention. Community crisis interventions (debriefings) and identification and referral of individuals who need additional support alleviate the recurrence of emotional distress (Koss & Harvey, 1991).

The following components reflect an ecological view of planning for

STS for providers in order to prevent deliterious effects. This view is dynamic, competency-based, and proactive.

COMPONENTS OF PREVENTION OF INDIVIDUAL STS

Several researchers have developed guidelines for stress reduction, burnout, and prevention that apply to caregivers of trauma survivors (Hamberger & Stone, 1985; Edelwich & Brodsky, 1980; Yassen, 1983; Lazarus & Folkman, 1984; Pines & Kafry, 1981; Freudenberger, 1974; Maslach, 1982; Cherniss, 1980; Holt, Fine, & Tollefson, 1987; Fischman, 1991; Smith & Steindler, 1983; Newman & Beehr, 1979; Medeiros & Prochaska, 1988; Flannery, 1987, 1990; O'Rear, 1992; Raphael, 1986; Mitchell, 1983). The recurring themes include the importance of active planning and involvement and a holistic, multidimensional approach that combines knowledge, strategies, and techniques. These interventions are secondary prevention if they build a foundation for individuals before a traumatic event or tertiary prevention if they are activated in the aftermath of trauma.

Personal

While many of these personal components may be common knowledge, it is important to make them explicit and to offer readers the opportunity to review their current status in these categories. They address the prevention of the deleterious effects of STS as outlined in Table 1, including its physical, psychological, cognitive, interpersonal, behavioral, and spiritual components.

Physical

Body Work. Body work means maintaining the health of our bodies. Having a well-paced life, as well as incorporating all of the other self-care components, will increase body self-care and decrease wear and tear.

The importance of vigorous exercise in stress reduction has been documented in the stress-management literature (Flannery, 1990; Sinyan, Schwartz, & Peronnet, 1982). However, for some, fitting exercise into their lives becomes an additional stressor. One colleague's solution was to exercise at work by walking up and down the stairs. It is recommended that one choose a form of exercise that fits one's lifestyle, and that may meet some other needs (e.g., desire to have time alone or, conversely, to spend some time with a friend, or to be competitive through team sports). Whatever form of exercise is selected, it is clear that doing it regularly increases one's overall strength, endurance, cognitive clarity, and sense of well-being.

Some trauma-treatment specialists emphasize the importance of additional nurturance. This can include massages, warm baths, therapeutic body work, wearing clothes that feel good, and buying household/office furniture and accessories that are pleasant to look at and are comfortable to live with.

In general, it is important to listen to one's body. It often will communicate what it needs, and is sometimes the first to know. Since it is important to keep it well tuned, regular physical examinations are suggested.

Adequate Sleep. From the wisdom of cartoonist Ashleigh Brilliant, (1974): "What I need is a well-deserved rest, but I haven't deserved it yet." Not everyone has this attitude, but it is commonly expressed in the trauma-treatment community. Thus a recent event or one's work may interfere with sleep.

Adequate sleep is essential to well-being. Those who have undergone sleep deprivation can testify to its debilitating effects, including impaired cognitive and neurological functioning and irritability. Be aware of how much sleep you need to function well. In experiencing specific kinds of sleep disturbances (e.g., inability to fall asleep, early rising, waking in the middle of the night, regular nightmares), be sure to address these problems before they become a pattern.

Nutrition. Eating good, nutritious meals is a vital part of human functioning. Unless we keep our bodies well fueled, we will not have enough energy to live our lives properly. Many of us not only do not eat correctly (i.e., balanced meals at regular intervals with selections from the four basic food groups), but may have developed poor eating habits as a result of our hurried, full lives—such as eating in our cars, having meetings during lunch, not taking a lunch break, or eating too quickly to permit proper digestion. Flannery (1990) maintains that stress can be exacerbated by the intake of refined white sugar, caffeine, or nicotine, and points to studies that tie the modification of the use of these substances to stress reduction. One caregiver relates that when she is under stress, it is not exercise that is the first to go, it is vegetables. In war or poverty affected areas, food supplies may be inadequate to meet nutritional needs.

Appetite also can be affected by stress. Some people tend to overeat, some to undereat, and others to substitute eating for having feelings. In understanding our relationship to food and nutrition, we first must become aware of what our eating patterns are now compared with what they were in the past, keeping in mind what, when, how, and why one eats. Then we must decide if changes are desired or needed. Changes in our eating habits are one of the hardest to make, so don't be too hard on yourself in the process.

TABLE 1
The Personal Impact of Secondary Traumatic Stress

Cognitive	Emotional	Behavioral	Spiritual	Interpersonal	Physical
• Diminished concentration	• Powerlessness	• Clingy	• Questioning the meaning of life	• Withdrawn	• Shock
• Confusion	• Anxiety	• Impatient	• Loss of purpose	• Decreased interest in intimacy or sex	• Sweating
• Spaciness	• Guilt	• Irritable	• Lack of self-satisfaction	• Mistrust	• Rapid heartbeat
• Loss of meaning	• Anger/rage	• Withdrawn	• Pervasive hopelessness	• Isolation from friends	• Breathing difficulties
• Decressed self-esteem	• Survivor guilt	• Moody	• Ennui	• Impact on parenting (protectivness, concern about aggression)	• Somatic reactions
• Preoccupation with trauma	• Shutdown	• Regression	• Anger at God	• Projection of anger or blame	• Aches and pains
• Trauma imagery	• Numbness	• Sleep disturbances	• Questioning of prior religious beliefs	• Intolerance	• Dizziness
• Apathy	• Fear	• Appetite changes		• Loneliness	• Impaired immune system
• Rigidity	• Helplessness	• Nightmares			
• Disorientation	• Sadness	• Hypervigilance			
• Whirling thoughts	• Depression	• Elevated startle response			
• Thoughts of self-harm or harm toward others	• Hypersensitivity	• Use of negative coping (smoking; alcohol or other substance misuse)			
• Self-doubt	• Emotional roller coaster	• Accident proneness			
• Perfectionism	• Overwhelmed	• Losing things			
• Minimization	• Depleted	• Self-harm behaviors			

Psychological

Life Balance. In Flannery's approach to stress reduction (1990), the first step is to reduce somatic arousal. This reflects the view that it is important to maintain a life that is marked by a diversity of activities as well as a moderate pace. It does not mean that there will not be periods in your life that are more stressful than others. Rather, it emphasizes the value of striving for an overall balance of work, outside interests, social contacts, personal time, and recreation. Life balance includes a commitment to life and life-enhancing activities.

Relaxation. As cartoonist Ashleigh Brilliant (1974) puts it, "Please don't make me relax, it's my tension that's holding me together." Those involved in trauma work find it difficult to relax because of the nature of this work, and because they may feel a mission to absolve the world of violence (certainly an important goal). Nevertheless, relaxation must be incorporated on a daily basis, as well as at more extended intervals (i. e., vacations). Relaxation can take the form of fun. Daily relaxation, sometimes called "downtime," can be short in duration, so long as it is regular.

Contact with Nature. With our absorption in the realm of human interactions, it is easy to forget that we live on Planet Earth. Once, while I was experiencing some major life transitions, a wise consultant suggested that I start a garden. She contended that the changes, the cycle of the seasons—the planting, the harvesting—would offer an important perspective on life, and literally would be "grounding" and an antidote to stress.

Contact with nature can give us a larger view of the world and our place in it. Even short trips to the park, a spontaneous canoe trip, watching the night sky, or a plunge into the ocean can be rejuvenating. Some clinicians may need longer stretches with nature, such as mountain climbing, snorkeling, hiking, camping, earthkeeper missions, skiing, or rafting. Caring for pets or plants can also be restorative, and animals can be a source of comfort as well.

Creative Expression. As our brains become more and more involved in the intellectual work of our professions or in trying to manage personal scheduling, we need to make a concentrated effort to engage the more creative parts of our minds. This can include, but is not limited to, writing, drama, photography, cooking, drawing, painting, dancing, handicrafts, utilizing one's sense of humor, or playing a musical instrument. Through creative expression, we become more expansive, and also may find new modalities for handling STS.

Skill Development. There are some skills that help to enhance the prevention of STS. These include:

- Assertiveness training. Learn and practice the skills associated with having the belief and self-confidence to stand up for oneself or to say "No" when necessary.
- Stress reduction. Learn comprehensive techniques that have proven effective in reducing the physical and mental effects of stress.
- Interpersonal communication. Learn about your personal communication style and how interpersonal interactions can be improved to enhance social or colleagial support.
- Cognitive restructuring. Evaluate how you view your situation and the world and learn more effective problem-solving strategies.
- Community organizing. Learn how to be an effective organizer in order to be more successful and satisfied in social action.
- Time management. Learn techniques to effectively set priorities and organize your time in a productive manner.

Meditation/Spiritual Practice. Meditation can be healing to the body and the spirit. Flannery (1990), Borysenko (1988), Kabat-Zinn (1990), Benson (1976), and others document how meditation can effect the well-being of the body. Blood pressure is lowered, breathing becomes more regular and efficient, and muscles are more relaxed.

Such practice does not change the reality of the external traumatic events, but it does minimize the wear and tear on the body, and assists in developing healthy coping strategies. The practice of meditation does not have to involve fancy techniques, following a certain guru, or many years of study. At its most basic level, it means paying attention to one's breathing and approaching life with an attitude of mindfulness.

Another dimension relates to spirituality, which may or may not entail connection with an organized religion. As mentioned before, the impact of trauma can be such as to shatter or impel one to reevaluate one's spiritual belief system. For some, this means a questioning of previously held beliefs: for others, it means turning for comfort and community to religious groups; and for still others, it means expanding their beliefs in new ways. Flannery (1990) reports that, in his study, those people who had a spiritual outlet underwent less stress.

We need to confront our spiritual beliefs and learn how to derive meaning from what we have personally experienced or to which we are bearing witness. We need to acknowledge the resiliency of the human spirit. This process will enable us to maintain a sense of hope and vision.

Self-Awareness. Prevention of STS is partially determined by the character of the individual. Therefore, an assessment of oneself is an important component of prevention. Lazarus and Folkman (1984) suggest evaluating one's health and energy, existential beliefs, problem-solving skills, social skills, social supports, and material resources. In providing trauma treatment, Medeiros and Prochaska (1988) stress the importance of self-

evaluation in maintaining optimistic perseverence, seeking inner peace, and instituting contigency control. It is important to understand which work or client situations may be particularly difficult for you. Evaluate whether you are really able or want to be objective in this situation.

This self-evaluation should be conducted with an openess toward acknowledging personal resources and identifying areas in which one would like to, and is willing to, change. It also means exploring who we are not. For instance, as a white person, one can never truly know what it is like to be an African American. Fischman and Ross (1990) remind us of the importance of a cultural–social–political anaylsis of ourselves and of this self-awareness in providing care.

Self-awareness denotes a nonjudgmental and compassionate attitude toward oneself, an understanding of one's current life circumstances, and a level of maturity that enables one to accept oneself. It involves a willingness adduce personal meaning from traumatic experiences, and to incorporate these lessons into a self view. It also means accepting the small ways in which one can take control in the face of powerlessness. A police officer noted how much satisfaction he was beginning to take in finishing his paperwork. It was a small way in which he could feel productive—by completing a manageable task.

Finally, self-awareness means knowing when outside help is needed.

Humor. Maintaining a sense of humor and using humor as a coping strategy are vital prevention techniques. Humor is increasingly adding a special dimension to our lives, as evidenced by the proliferation of comedy clubs and the publication of Norman Cousins' (1979) popular book, *Anatomy of an Illness*, which describes his use of humor in the face of his terminal illness. Humor can reduce stress, release tensions, and allow us to keep an emotional distance. Socially, humor can create group cohesion, or it can afford a vehicle for social criticism (Dyergrov & Mitchell, 1992; Flannery, 1987, 1990; Kelly, 1977). But there is clearly a difference between using humor at the expense of others and having the "ability to laugh at oneself and to see lightness in everyday joyful and tragic events" (Kelly, 1977).

Social/Interpersonal

Social Supports. Since trauma from abuse results in the breach of attachments with others, for survivors of abuse, connections with other people are restorative. This is true for caregivers as well.

Social supports are a central component of the prevention of personal and professional STSD, and it is important to expand one's interventions beyond a focus on the individual to a focus on one's social network. This involves evaluating the quality of the network. An analysis might question your supports' understanding of and belief systems concerning trauma; their availability, resourcefulness, and ability to give and receive feedback; and their receptivity to change. Once this analysis is complete, one may decide to make changes by either adding to or subtracting from current sources of supports.

In addition to evaluating or changing one's support system, there may also be the task of educating social supports about one's needs and experiences. This education process may include the challenge of changing the attitudes and the skills of those whom one cares about. It is crucial to build in regular time with loved ones, friends, and acquaintances in order to nurture our connections with others. If it is a loved one who has been traumatized, time away and support from others can be useful. This time out may feel like an additional burden, but it is one of the vital forces militating against isolation and the stress of secondary victimization. Included should be time with children, if at all possible. Children bring a fresh view of life and demand that one be in the moment with them. They offer feelings of hope, joy, beauty, and playfulness to counteract the more heinous aspects of human nature to which we are exposed in our work.

Getting Help. Getting help is not something for which people generally plan. However, if a foundation is laid, help can be more accessible and more effective. Accepting and accessing help in a timely manner has been associated with preventing the long-term effects of post-traumatic stress. Establishing a plan of help includes developing the attitude that getting help is a sign of personal strength, identifying specific people in one's personal and professional life who are viewed as helpful, and becoming familiar with professional resources should one choose to use them.

Social Activism. Another way to maintain a sense of hope and purpose in doing trauma work is to be involved in social activism. This has the effect of combating the feeling of powerlessness that results from STS, as well as of providing a sense of shared mission with others, which can mitigate social isolation. There is wisdom in the saying, "There is power in numbers." Holmes (1981) describes the importance of class advocacy combined with case advocacy for enhancing one's self-worth, as well as for improving services. Comas-Diaz and Padilla (1990) suggest that a sense of social responsibility helps to contain horror.

Social activism may or may not be related to the trauma. For one person, working on an antiviolence public education campaign can be valuable, whereas someone else may find meaning in working for the establishment of a new neighborhood playground. Members of the Victims of Violence Program of Cambridge Hospital engaged in social activism as a team by having a public statement in support of Anita Hill, a law profes-

sor who came forward to report sexual harassment by their Supreme Court nominee, Clarence Thomas, read at the 1991 annual meeting of the International Society of Traumatic Stress Studies.

Social activism can also be an outlet for frustration. Letting the public know your views, beliefs, and ideals can be an antidote to the secretive and silencing nature of trauma. What may seem like small acts of activism can also combat powerlessness. For example, residents and workers in a refugee camp organizing bus service to take them to town twice a week. Social activism offers the opportunity to change the present and the future, while the past can only be confronted and, learned from, but not changed.

Professional

While Table 2 delineates the ways in which STS can affect professional functioning, the following guidelines are suggested for the prevention of professional STS.

Balance

Balance is important in several ways. One issue is how much work to do—the number of work hours per week and the proportion of the work that relates to direct trauma treatment. It is important to have diversity in one's work life. For example, if working on the hotline in a battered women's shelter, or acclimating new residents to the shelter, it may also be important to have the opportunity to work on public education, do administrative tasks, or become involved in other professional activities. In other words, to have balance in the quantity and quality of tasks in one's work life is crucial.

Another aspect of balance is pacing. This means paying daily attention to the effects that your work is having on you and creating a pace that will maximize your emotional and physical health. Pacing includes taking regular breaks, making time for meals, and taking vacations.

Boundaries/Limit Setting

Setting good boundaries is important for self-care, as well as for providing a model for those to whom care is provided. Boundaries have several components.

Time Boundaries. These include being on time for appointments and being careful not to go over the specified time. Although going beyond the time limit can be seen as a sign of caring, it can also be perceived as a broken contract or create fear of the unknown. These are particularly sensitive areas for trauma survivors. It is also important that we guard our own time boundaries so that there is the opportunity to have a balanced life.

TABLE 2
Impact of Secondary Traumatic Stress on Professional Functioning

Performance of Job Tasks	Morale	Interpersonal	Behavorial
• Decrease in quality	• Decrease in confidence	• Withdrawal from colleagues	• Absenteeism
• Decrease in quantity	• Loss of interest	• Impatience	• Exhaustion
• Low motivation	• Dissatisfaction	• Decrease in quality of relationship	• Faulty judgment
• Avoidance of job tasks	• Negative attitude	• Poor communication	• Irritability
• Increase in mistakes	• Apathy	• Subsume own needs	• Tardiness
• Setting perfectionist standards	• Demoralization	• Staff conflicts	• Irresponsibility
• Obsession about details	• Lack of appreciation		• Overwork
	• Detachment		• Frequent job changes
	• Feelings of incompleteness		

Overworking. This includes taking on too many responsibilities, working overtime on a regular basis, constantly bringing work home or taking calls at home, and being unable to separate from the work emotionally. In the extreme, this can mean actually taking clients home. Even excessive reading can be a form of taking clients home, and can be an attempt to overcome feelings of inadequacy, incompetency, or helplessness.

Therapeutic/Professional Boundaries. Since the core of abuse is the violation of boundaries, it is important that the care provider and the client have an understanding of the nature and the process of the helping relationship, and of therapy itself. When one is in the care of others in the aftermath of trauma, this can bring up feelings on the part of the client that are not always understood. Some of the feelings of rage, helplessness, and so on, might be projected onto the caregiver. It may be hard not to take these feelings personally. Understanding the nature of the therapeutic or helping relationship can help to depersonalize possible abuses by those receiving care. Explaining the reasons for particular interventions can defuse the situation.

Personal Boundaries. It is important to resolve how much of oneself to disclose to clients and under what circumstances. An example of this dilemma is the therapist who is pregnant and is treating survivors of childhood sexual abuse. How does she respect the possible jealousy, as well as natural curiousity, of her clients while balancing her desire to maintain her privacy and her joy about the upcoming birth of a child? What does she do with her own resentment? Or consider the clergy member who has lost a child to gang violence. When is it appropriate to disclose his experience to those in his care?

Human service workers who live and work in refugee camps or other ongoing traumatized communities may have to be extremely creative in creating boundaries for themselves. One worker whom I met in Croatia, decided that she would have a schedule for when residents could come to see her and that she would only see a certain number of people a day. The basic structure and intervention offered her hope of creating some boundaries between herself and the onslaught of urgent needs and requests that her fellow refugees brought to her.

Service providers must understand the importance and implications of physical touch for trauma survivors. This affects their own as well as their clients' personal boundaries. It can have different meanings, depending on the kind of trauma. Different work settings may also have different standards concerning touch. Nurses and doctors regularly use touch in the course of their work. In addition, there seems to be more of a norm for physical contact in bereavement groups in the aftermath of murder than in groups dealing with the aftermath of childhood sexual abuse. Service providers who are therapists must decide what role physical touch should play in their clinical practices.

Dealing with Multiple Roles. Clinicians may be undergoing their own healing processes and thus may meet their clients in other environments (e.g., Al-Anon, Alcoholics Anonymous, or other mutual-help groups). They should be prepared to handle these situations. It is usually the case that human service workers will have to limit their own activities and find resources that will feel comfortable for their healing, and they may sometimes feel as though their own support system is being compromised. This is not always an easy task. Sometimes there is a scarcity of resources and sometimes you are living and working in the same communities so multiple roles are more a part of your daily lives.

Realism. Knowing our limits in doing this work is important as well as humbling. We cannot be the parents that our clients never had, we cannot erase the Vietnam conflict or the Holocaust, we do not have the power to eliminate interpersonal violence. No amount of work or self-sacrifice can ever achieve such goals. Pines (1986) reminds us that we have to accept the limitations of insight in the face of massive traumatization. It is important to take the time to appreciate what we actually are doing and the contributions that we are making to help the world become a better place. Sometimes, when we are in the midst of the work, we do not see its effects, or if a client does not improve, we focus on our failings. We also may not have the opportunity to witness the full recovery process. For example, if we have only provided crisis intervention services, we may not be able to observe over the long term how a family eventually adapted to the murder of a loved one. If you are working with people who are continuing to be in ongoing danger, you may help them face the realities of their situation or provide them with some temporary relief, but you may not be a part of their lives to help them pick up the pieces when the violence has ceased. Or, you may be working with children or teenagers who do not have developmental maturity to integrate some of the meaning of the trauma that they have experienced, so you may feel good about the tools you have taught them, but may not see them as they integrate the meaning of their pasts into their adult lives. Take the time now to appreciate the efforts of your work.

Getting Support/Help

Etzion and Pines (1986) and others (Himle, Jayaratne, & Thyness, 1991) have documented the importance of social support in moderating the negative consequences of stressful life events. The key element in developing a support structure is that it be emotionally safe to be able to talk honestly about the impact of one's work on one's own life. The tim-

ing of support is also important. Some caregivers prefer immediate support, whereas in other situations, as Dyregrov and Mitchell (1992) point out, they may still be functioning in an emotionally distant mode and could benefit better from support after a delay. The development of trusting professional relationships ensures that there will be those who will notice that one is having difficulties, and will be available for support or to make recommendations. Various kinds of support are available.

Peer Support. Peer support means that one has the opportunity to receive from and give support to colleagues who are involved in similar work tasks. This support should be in addition to or in conjunction with clinical support, and can take place on or off one's work site. In their classic article on vicarious traumatization, McCann and Pearlman (1990) describe a weekly case conference meeting in which their staff members spend the first hour discussing and conceptualizing difficult cases and, the second hour as "feelings" time in which to process their own reactions. Off-site groups have the advantage of including a variety of people from different settings, and, therefore, can offer varying perspectives. Peer support may also come more informally as speaking with a co-worker.

The benefits of peer support include nurturing colleagiality, as well as relieving isolation. It is important for caregivers to have a variety of peer support resources to allow easy access to the immediate, uncensored ventilation of feelings, and to be able to share with others the burden of bearing witness to traumatic events. Isolation can also be reduced by such strategies as setting up coleadership of groups, teaching, or responding to crises in pairs, which help as well to reduce feelings of helplessness and powerlessness.

Peer support can help with finding an equilibrium and can assist with the elimination of STS symptoms. Peer groups offer a sense of continuity over time (Kaplan, 1992). As members get to know and trust each other, they can help one another to recognize their professional "blind spots," as well as to develop professional challenges.

Supervision/Consultation/Therapy. No matter how experienced we are, it is important to build in supervision or consultation on a regular basis. It is crucial to get an outside perspective from someone trusted or to receive guidance in facing a new challenge. Supervision provides the opportunity to have someone listen solely to us, as we have had to do with our clients. If this is not available at work, outside arrangements should be made.

Consulting with an expert can be particularly helpful and reassuring. For example, one colleague began an evaluation with a woman who revealed that her estranged husband had been following her. After consulting with an expert on battered women, the clinician decided that it did not make sense to continue to provide services to this woman in the context of private practice, as it might not be safe for either of them. She recommended a group at a battered women's shelter, together with continuation of the evaluation at a hospital-based outpatient treatment facility that could assure security for both client and practitioner.

Outside consultation can also be an important resource for staffs to evaluate the ways that their group as a whole may be manifesting symptoms of STS. When one realizes that personal and/or professional functioning become impaired, it is important to seek out therapeutic resources to supplement professional ones.

Role Models/Mentors. Finding other professionals whose work, style, writing, ability, or the like, one admires can be a source of inspiration and professional growth.

Plans for Coping

With full understanding of the impact of trauma work, it is important for caregivers to develop their own self-care plans for their workdays. These plans should include the various components outlined in the section on personal prevention. In addition, caregivers should plan for the periods before, during, and after client meetings, and for emergency situations (e.g., a client suddenly reports suicidal or homicidal thoughts, or is threatening). Trauma-survivor caregivers should be prepared in the event that new memories or flashbacks occur during meetings. Another particularly vulnerable situation that may need additional coping strategies comes from work with children. Helpers may find that their usual coping strategies are inadequate in caring for two children who have been traumatized since children are unable to protect themselves (Dyregrov & Mitchell, 1994). If children have been killed or who have lost parents, this may evoke particularly strong feelings and call for particularly active coping plans.

Emergency workers (e.g., police officers, ambulance attendants, healthcare providers) need to develop personal guidelines that incorporate regular coping strategies. Dyregrov & Mitchell (1992) found that emergency personnel developed certain on-scene coping mechanisms, such as using activity to restrict reflection, consciously suppressing emotions while in the moment, actively avoiding thinking about the ramifications of the event, preparing themselves mentally, regulating the amount of exposure to stressors, focusing on some task or distraction, or finding a purpose in performing the task. Coping strategies should also include contact with colleagues on a regular basis. Again, this breaks the isolation and sets up a climate in which workers are encouraged and expected to

exercise self-care. Plans for coping should include cognitive and mental preparation, with possible role plays of potentially difficult situations.

Evaluation of One's Own Healing.

For clinicians who are also trauma survivors, it is important to remember that survivors have something unique to offer this field (Kaplan, 1983; Shrum, 1989; Scurfield, 1985; Yassen & Schatzow, 1991; Yassen, 1993). It is the survivors themselves who have taught caregivers about the nature of the recovery process. However, as an individual, there needs to be a self-evaluation by the clinician of the personal motivations for doing this work and of where he or she is at in the recovery process. In early recovery, there are risks of overidentifying with clients or confusing personal healing with clients' healing. It may be tempting to work on one's own healing by helping others work through theirs. This should not be done. Survivors need their own space and time and some distance from the process to be able to achieve a balance in life. Also, having experienced a traumatic event does not mean that one is qualified to help other survivors. One must ascertain what in one's own experience may be useful to others, and what skills and training are needed in order to help them. For some survivors, helping others may be a defense against their own pain, or something they do because they feel as though they "should" in order to keep the memory alive.

If one has been in recovery for a while and suddenly recovers new memories or goes through a life transition that initiates another healing cycle, one may begin to question one's own skills and competency as a caregiver. Healing, however, is a lifelong process. At some points, it may be important to take breaks for self-care. This should not be confused with professional incompetence. And this is true for any caregiver and for any issue that may have personal relevance for clinicians (e.g., working with cancer patients as a cancer survivor, working in adoption having experienced infertility).

Healing takes place on a continuum, and survivors who are also healers must continually evaluate and reevaluate what their own needs are in this process. It is crucial that a setting be provided in which survivors who are also caregivers can talk openly and candidly about the interface between their own experiences, countertransference, and vicarious traumatization. In the Boston area, treatment interventions are available specifically for female therapists and human-service professionals with a history of sexual abuse (Yassen & Schatzow, 1991). Two models that have been developed are a daylong workshop focusing on issues of self-care and a 12-week, time-limited group model. These interventions have been effective in reducing isolation and increasing participants' coping skills.

Recently, I participated in a U.S. government–supported project that provided workshops for human service providers in Croatia and Bosnia to learn about the various levels of impact that the war is having on them and to develop action plans to address the issues of STS. This demonstrated worldwide acknowledgment of the importance of the mental health of human service providers.

For nonsurvivors, as well as survivors, doing this work may trigger memories of prior losses, even if they were not trauma related. These need to be attended to in order to prevent their interference with work and/or emotional well-being. One caregiver revealed, "I thought that I had finished grieving my mother's death until someone was referred to me whose mother had been murdered. I realized that in fact I had avoided dealing with my own mother's death by immediately going back to work. I was surprised that even though she had died 10 years ago, hearing about this murder caused flashbacks to my own mother. I went to a bereavement group, and not only do I feel much better, I really believe that I am a better therapist."

Professional Training

It is essential to access the adequecy of one's training in preparation to do trauma treatment. In the past, professional training schools of social work, psychiatry, and psychology perpetuated societal denial of the prevalence and impact of violence on human lives. Newberry (1985) contends that many clinicians believe that PTSD symptoms can only occur with people who are predisposed characterologically. This assumption perpetuates professional denial that human disasters can strongly affect well-adjusted people. Herman (1992) suggests that this denial *in mental health professions* leads to professional isolation of those professionals who work primarily in the field of trauma. These theoretical differences can lead to conflicts with colleagues as well as to the subtle stigmatizing of trauma survivors. Our professional identies can be used as a defense against feeling the pain that exists from trauma. This can result in a victim blaming, distancing, or devaluing. Many survivors who are professionals feel unable to speak openly about their histories for fear of being judged by others and objectified and having their motivations questioned.

Fortunately, there has been a proliferation of conferences, workshop, and professional organizations that offer the opportunity to supplement existing skills and to reevaluate prior values and assumptions. Seeking out new and different sources of training (e.g., collaboration of veterans groups and rape crisis centers) enriches one's knowledge base and combats misinformation that still exists in some settings. Kelly (1970)

reminds us again about the importance of interdisciplinary interaction and learning.

In certain professions, there seems to be a reluctance to new and varied sources of learning. Colao and Hunt (1983) report that professionals who received degrees from institutions of higher education found it difficult to assume the role of students in trainings provided by rape crisis center staff, despite the reality that was the rape crisis movement that first brought the issue of rape to public awareness and developed the first models of rape crisis counseling.

The values that are sometimes taught in professional training also need to be challenged. One such value is the "neutral stance." Herman (1992) describes the process of neutrality as the therapist (caregiver) refraining from advancing her/his personal agenda. However, it has come to mean that therapists appear blank. Herman makes an important distinction between "maintaining technical neutrality" and taking a stance against human-induced violence while maintaining a neutral environment in which a client is free to explore the many responses to his/her victimization (including fantasies of graphic revenge or ambivalence towards a batterer). This is often difficult to do and professional training inadequately addresses these issues.

Another important contribution training can make is to provide a theoretical framework that not only informs the kind of interventions to be made, and also offers intellectual containment in the face of violence and the powerlessness/helplessness it can engender. Theoretical understanding through training or reading professional literature can be a preparation for what may be encountered in the aftermath of trauma. It can provide structure and emotional distance. As a caregiver, this preparation can provide an anchor to assist with feelings or affect and being more present for the people in one's care.

Professional training and identity can be enhanced through participation in professional organizations. Professional activism offers the potential to make changes in training curriculum and can also help to change professional attitudes towards trauma survivors, treatment, and the impact of STS on caregivers. Affiliations with national and international organizations can combat overwhelming feelings of the isolation that results from facing violence and its aftermath on a regular basis.

Kelly (1970) also contends that training can lead to an attitude of arrogance. One antidote he offers for arrogance in training psychologists (and probably all professionals) is for them to become participants in local community activities and events. This keeps helpers in touch with the reality in peoples' lives and contributes to the broadening of the definition of competent helpers.

Another important component of professional training and identity is participation in professional organizations. Professional activism offers the potential to make changes in training curricula, as well as in professional attitudes toward trauma survivors, treatment, and the impact of STS on caregivers.

Job Commitment

We all need to evaluate regularly our commitment to the work we do. Is this the right setting? Is this the right content area for me? Do I need additional training? Am I stuck here? What are my short- and long-term professional goals?

Fogelman & Savran (1980) note the importance of analyzing our personal motivations for doing trauma treatment at all, and suggest such possible motivations as the desire to acheive social and political goals, survivor guilt, or the ability to empathize with people who come from similar situations. Thus it is necessary to consider exactly why one is doing this type of work. Perhaps, too, the intensity of doing trauma work can become a reinforcer in itself.

Many caregivers report job satisfaction because they consider trauma work meaningful. They describe a growing compassion for others; an ability to tolerate a larger range of feelings, both within themselves and in others; and a feeling that they have gained wisdom from the people whom they have met. Whatever one's motives, one must make conscious decisions about one's commitment and devise ways to include optimism. Although not everyone has choices or can control the work situation, with reflection, one will be able to do better trauma work and can make better plans for preventing STS.

Replenishment

Those who have chosen human services as a profession are involved in giving care to others. We, too, are a mini "ecosystem." We must be sensitive to our own needs for professional, as well as personal, replenishment. Sometimes the two can be combined. For instance, one can travel to a conference in an unfamilar city, or attend a local workshop with a colleague whom one would like to know better. There is a natural human desire to learn and to grow. In fact, Penn, Romano, and Foat (1988) report that the opportunity for professional development is the one consistent factor differentiating those who are satisfied with their jobs from those who are not. There needs to be continual professional opportunities to challenge oneself, to be exposed to other points of view. Updating ourselves with new information also ensures that we are offering the people in our care the most up-to-date skills available.

Replenishment also means participating in other work-related activities that are challenging and different (e.g., research, education, training). It may also mean making contributions to the field so that others may learn from one's ideas and experience. Replenishment keeps the ecosystem of our lives nourished and functioning well.

COMPONENTS OF ENVIRONMENTAL-STS PREVENTION

As mentioned before, individual prevention is only one component of STSD prevention. Environmental prevention interventions are another. Prevention of environmental STSD mainly rests on secondary and tertiary prevention activities, since they entail planning, preparation, and larger societal issues (see Figure 1). It is possible, however, that the catalyst for implementing some of these interventions may have resulted from experiencing STS or crisis intervention, and, therefore, arose from a tertiary prevention activity (Figure 1). The three areas of management of envjronmental STS addressed are social, societal, and work settings.

Social Setting

Another part of one's environment is society at large, which may be evidencing denial, misinformation, or prejudices. Societal actions include:

- Educational interventions—utilizing activities aimed at changing attitudes or providing information
- Coalition building
- Building alliances with various groups in order to exert a greater influence
- Legislative reform—using the legal system to enforce rights
- Social activism—planning actions that include public activities to draw attention to a problem, usually, but not consistently, through the law
- Mass media education and global communications

Work Setting

Just as the work setting can impact STS and STS can impact the work setting, interventions directed toward the work setting can influence job satisfaction, self-care, and prevention of STSD. Thus one needs to assess the environment in which one is working (Quick & Quick, 1984). On a physical level, this includes such things as having an office, as well as,

lighting, noise level, accessibility, furnishings, privacy, environmental safety, security, employee amenities (e.g., access to coffee, lunch, office supplies, secretarial assistance, places in which to take breaks), and availability of colleagues.

Other aspects of the work environment are less tangible, and relate to the values, expectations, and culture characterizing the setting. Having a clear philosophical value base has been identified by Harvey (1985) as a key element in comparing rape crisis centers. Other values may go unstated, but clearly have an effect on work settings. For instance, in some settings, it may be assumed that if employees do not work overtime, they are not committed to their work, or that clinicians who do not take vacations are more committed to their work than are others.

Workers need to understand the explicit as well as implicit demands of their work environments. Self-care can best be achieved if management's policies are made clear to employees. Some important aspects to clarify are as follows:

- Value system
- Tasks: job descriptions, philosophy, realistic expectations, task variety, adequacy of supervision, in-service and career opportunities, training and orientation that prepare the employee for the job, job security, job overload, pay
- Managerial: lines of authority, accessibility of leaders who are open to feedback, role models, accountability, ability to motivate/build morale
- Interpersonal: personnel guidelines, respect for differences, value of social support/mutual aid, trust among staff (cooperation vs. competiton), sensitivity to the needs of individuals (e.g., personal days, stress management training)

IMPLEMENTATION OF A PREVENTION PLAN

Transforming ideas for prevention planning into action is often difficult. Kelly (1977) offers important principles to help in designing an ecological prevention plan. A primary consideration is that prevention changes over time. Prevention planning requires honesty about committing time and developing long-range plans that can be adapted to new personal and environmental resources. Besides maintaining this overall "attitude," it is important to remember that each personal and social setting is unique, and so will require its own prevention plan developed to meet its own culture. However, Kelly reminds us that more than one set

of ideas is always needed. Others have associated being active in creating prevention planning as a significant factor in reducing stress and burnout (Koss & Harvey, 1991; Lazarus & Folkman, 1984).

From the Author's Experience

With these principles in mind, I will use some of my own experience to illustrate STSD prevention planning over a span of 20 years. The prevention strategies are identified in parentheses.

I began my career in antiviolence work in 1972 as a cofounder of the Boston Area Rape Crisis Center, or BARCC (social activism, facing societal myths, community involvement, learning new skills, social support). Surviving my continuing involvement with BARCC, I have answered the 24-hour hotline, provided individual and group counseling, trained and supervised volunteers, served on countless committees, remained with the group as it became transformed from a feminist collective to a feminist hierarchy, testified before local and national legislators regarding legislative reform, furnished training and education to hundreds of community and professional participants and the media, and participated in statewide planning efforts to address the issue of sexual assault (diversity of tasks and audiences, social action, articulated value system).

From 1973 to 1975, I attended graduate school, where I completed my master's degree in social work, participated in my first consciousness-raising group, and fought with professors about the relevancy of the impact of sexual assault (training, replenishment, colleagial support, facing professional denial). After graduate school, I continued my affiliation with BARCC, and worked full time planning and providing services for developmentally disabled offenders and victims (more diversity). At the time, I was also teaching Sunday school (spiritual connections and involvement with children). To survive the collective group process of the rape crisis center, I learned to knit (creative expression, humor).

My career continued as I added two new components (reaffirmation of job commitment). One was integrating into it an international aspect of antiviolence work by providing training in other countries and consulting with international programs (worldwide social activism, expanded social supports, teaching, replenishment, multicultural diversity, recreation, nature and beauty). The second was becoming affiliated with the Victims of Violence Program at Cambridge Hospital. This affiliation has given me the opportunity to work with colleagues whom I respect, to be involved with developing a team that tries to put into practice the principles that it is trying to teach, and to participate in an academic environment that values teaching and research. Through my work with

our CCRT, I am able to apply my skills to community situations and to maintain a realistic perspective while changing my skills and adapting them in a changing world (community context, multicultural diversity). We also have a program that offers graduate- and postgraduate-level training in a variety of disciplines (colleagial support, replenishment, task diversity, balance of job tasks, environmental-change agent, work-setting challenges, role models, teaching opportunities). I continue my connection with the "real world" through BARCC, and take part in as many demonstrations as I can (diversity of ideas, social change). I am associated with several citywide and statewide coalitions to implement educational programs and to respond to issues as they present themselves on an ad hoc basis (social activism, multidisciplinary affiliations).

Through the years, I have faced many political and emotional challenges. One that stands out is maintaining my involvement in both grassroots organizations and professional groups, which often do not understand each other's perspectives and what each has to offer.

Another challenge has been to face my own blind spots and, vulnerabilities, regarding multicultural diversity. The Boston area is a community that not only is routinely segregated according to ethnic group, but also reacts to the same historical influences that result in racist attitudes in society at large. I have made a personal committment to combat racism, classism, heterosexism, sexism, and the various other "isms," and the self evaluation that entails. This evaluation has led me to assess that kinds of services that are provided, and their accessibility, value base, and assumptions about the people who are served. It is easy to avoid such issues and focus instead on service delivery, not only because of the emotions they evoke, but also because there are institutional and societal resistances to meeting the challenge.

As my life has progressed professionally, so it has personally. I have needed to explore over the years my motivations for continued involvement in this work (self-awareness). I have done this through personal psychotherapy, as well as through professional support groups, especially one peer group that I have been in for 10 years (colleagial support). I have two children and a number of close friends, all of whom tolerate my mood swings (social supports, children, humor), life balance, and who can offer me different life perspectives.

I have also learned some new skills that I have added to my self-care tool kit. The main one is meditation. The passage of time has been helpful as well. I now have a broader perspective, and sometimes more patience. I am able to see that everything does not happen at once, and that self-care and prevention of STSD can take place in different cycles. This perspective has afforded me understanding of the process, as well as hope

for achieving the prevention of the deleterious effects of STSD. Making mistakes is also inevitable, and an important part of the process, which I need to become more tolerant of. I have learned about the importance of reaching out and accepting help. One thing that I would still like to change is that sometimes I seek help only after I have passed my breaking point. In writing this chapter, I have needed help in countless ways (emotional, technical, professional, spiritual), and have found new ways of getting it, which I have now included in my "getting help" repertoire.

While my case is illustrative of just one person's experience, the guidelines are applicable to caregivers in general, whether street workers, therapists, relief workers, emergency workers, significant others, clergy, law enforcement personnel, or any professionals furnishing human services. In general, the successful implementation of a prevention plan involves an understanding of the personal characteristics of the individual, the social and cultural atmosphere in which he or she was raised, and the contemporary work and social context in which he or she currently lives. Personal and environmental obstacles need to be assessed in order to develop a realistic prevention plan. As the descriptio of the ecological framework points out, it is important to select goals from both the individual and environmental components of prevention planning. Figure 2 provides a summary of the ecological framework of STS prevention. The following guidelines are offered to assist in developing a prevention plan.

1. Review current self-care and prevention functioning.
2. Select one goal from each category (individual and environmental, Figure 2).
3. Analyze the resources for and resistances to achieving this goal.
4. Discuss goals and implementation plan with support person(s).
5. Activate plan.
6. Evaluate the plan weekly, monthly, and yearly with support persons.
7. Notice and appreciate the changes.
8. Repeat step 1.

CONCLUSION

The impact of affording care to those traumatized by violence can be all pervasive. Secondary traumatic stress is a natural consequence of giving this care. This chapter provides an understanding of the various levels of prevention, and offers an ecological model for individual and envi-

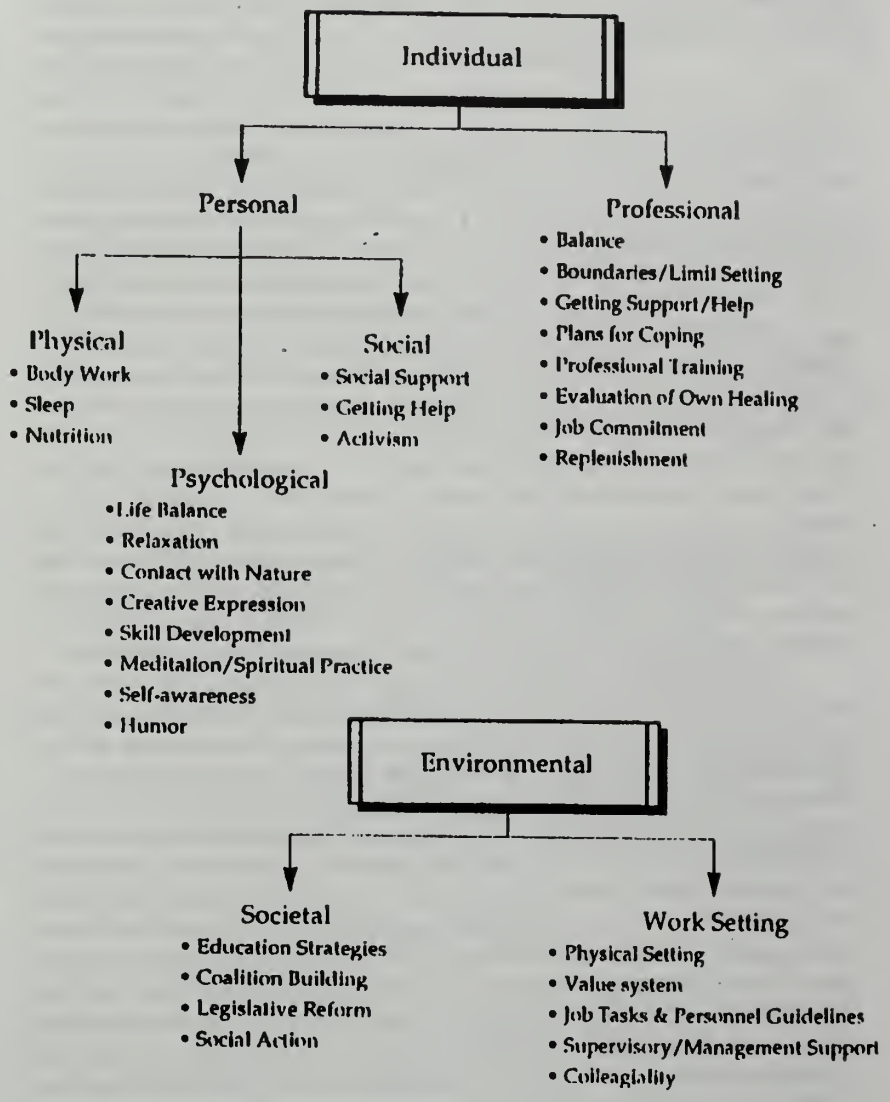

Figure 2. Ecological model for the prevention of STSD.

ronmental prevention. Although the focus is on the prevention of STSD in individuals, it is important to stress that it is not the individual's sole responsibility to prevent individual STSD. Primary prevention activities require long-term planning, and sometimes are more difficult to implement. However, it is the joint responsibility of policy makers, administrators, educators, and professional caregivers, as well as individuals, to ensure comprehensive prevention planning that includes primary in addition to secondary and tertiary interventions. Some of these settings are addressed elsewhere in this book. There are other areas that this chapter was not able to cover that need to be further explored, such as gender issues, multicultural influences, developmental issues, a more in-depth understanding of the physiological affects of stress, and the prolonged effects of STS.

The plans suggested here are designed to prevent the potential negative effects of secondary traumatic stress. Such prevention can be implemented through awareness, planning, and action. This chapter, it is hoped, has provided guidelines for all three.

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2

Survival Strategies: A Framework for Understanding Secondary Traumatic Stress and Coping in Helpers

PAUL VALENT

In order to understand the secondary traumatic stress (STS) reactions of those who deal with traumatized people, it is necessary to understand the responses of the primary victims, because it is the primary victims' responses that evoke the secondary responses. This chapter explores which specific responses arise in which situations, as well as their secondary effects and their means of transmission.

Whereas one line of traumatic stress literature deals with the reliving and avoidance responses in post-traumatic stress disorder (PTSD) (APA, 1987), another describes a very wide variety of often contradictory responses in traumatic stress situations. For instance, among other impact phase responses, Raphael (1986) notes numbness and apathy as well as arousal and resoluteness; effectiveness as well as helplessness; fight as well as flight.

Editor's Note: In this chapter, Valent proposes a solution to an important problem in the psychotraumatology field: the need for a framework that can accommodate the great variety of sources of stress and methods of coping with these stressors from a psychological, social, and biological perspective. Valent's model, presented in Table 1, is organized around eight survival strategies: rescuing, attaching, asserting, adapting, fighting, fleeing, competing, and cooperating. Valent suggests that the secondary traumatic stress responses may be elicited in helpers through identification with, and/or complementing victim survivor strategies. Secondary traumatic stress disorders may develop if the identifications are too intense, the complementing survival strategies are inappropriate, or helpers cannot execute their own survival strategies adaptively.

In a previous paper (Valent, 1984), I suggested that contradictory and fluctuating responses in disasters depend on changing survival responses to rapidly fluctuating circumstances. In this chapter, I explore further these different survival responses, which I call survival strategies (SSs). I suggest that while PTSD draws attention to the reliving and avoidance of traumatic stress responses, SSs provide a framework for the variety of physiological, emotional, and behavioral responses that are relived and avoided. I postulate that there are eight basic SSs that have evolved to deal with severe threats: rescue, attachment, assertiveness, acceptance, fight, flight, competition, and cooperation. I draw on evidence for the SSs from the fields of anatomy, physiology, ethology, anthropology, sociology, psychology, and traumatic stress.

BACKGROUND

Hippocrates wrote: "It is changes that are chiefly responsible for diseases, especially the greatest changes, the violent alterations. . ." (Dubos, 1968). Since his time, this principle has undergone a continuous cycle of being forgotten and then rediscovered and described under different labels. Trimble (1985) has noted this phenomenon for modern times. For instance, "shell-shock" and Kardiner's (1941) "[post]traumatic neurosis" came from World War I, and "combat exhaustion" (Bartemeier, Kubie & Menninger, 1946), "A-bomb disease" (Lifton, 1967), and "survivor syndrome" (Krystal, 1968) came from World War II. PTSD is a legacy of the Vietnam War. In the same period, many labels stemmed from specific disasters, such as "railway spine" (Clevenger, 1889) and "Buffalo Creek syndrome" (Titchener & Kapp, 1976).

Each of these syndromes included biological, psychological, and social manifestations. This is important to note because another series of developments in the understanding of traumatic stress arose separately in biological, psychological, and social streams of stress research, representing three perspectives with little cross-fertilization. However, they meet again in SSs. Let us now look at the three historically separate streams.

Biological Perspective

Early research was statistical/epidemiological and physiological. Statistically, a variety of traumatic situations, such as concentration camps (Eitinger, 1973), prisoner of war camps (Beebe, 1975), natural disasters (Bennet, 1970; Raphael, 1986; Trichopolous, Katsouyanni, & Zavitsanos, 1983), and bereavement (Raphael, 1984) were seen to lead to

the increased incidence of physical morbidity and mortality, as compared with control populations. However, even in more ordinary situations, the more intense the stresses, the more serious were a wide variety of consequent illnesses (Holmes & Rahe, 1967). This was part of a generality approach: stress gave rise to illness.

In contrast, specificity theories held that certain types of stresses in certain people were associated with certain specific illnesses. According to Alexander's (1950) basic premise, specific emotions must have specific physiological correlates, which in a conflict (stressful) situation, and with particular physical vulnerabilities, lead to specific symptoms and illnesses. He examined seven such "psychosomatic" illnesses, including hypertension, duodenal ulcer, and asthma. Weiner (1977) updated the theory in the light of much more complex physiological data. However, and this is the situation till today, although prediction is easier in individuals in whom certain stresses reevoke the same illnesses, stresses add little statistical (even if significant) weight in predicting specific illnesses over large populations. Although some used this fact to discredit the importance of stresses in illnesses as artifacts (e.g., Andrews & Tennant, 1978), it may be that greater sophistication is needed to gather stress data (which may, in fact, be underreported [Monroe, 1982]) to identify core phenomena in stresses that are significant, and to identify intervening variables that need to be controlled. Thus, even though the paradigm of stress leading to specific illness has been very promising, its clinical use has been compromised by conceptual difficulties.

Physiological research involving the autonomic nervous system (Gellhorn, 1970), hormones (Mason, 1968), the immune system (Ader, 1981), and a variety of neurotransmitters and neuromodulators (Smith, 1991) indicated a close association of all these systems with, and their high responsivity to, a wide range of stresses. New techniques made this area a fertile field for study. Yet the situation has remained basically the same as in 1968, when Mason called for a taxonomy that could make sense of the great variety of physiological responses evoked in different stress experiments. Again, clinical use has been hampered by conceptual difficulties.

Psychological Perspective

Epidemiological studies have long suggested that major stresses are followed by a variety of psychological dysfunctions. Kinston and Rosser (1974) have suggested a 400% increase in nonpsychotic disorders following disasters. In reviewing the literature, Raphael (1986) found that between 20% and 70% of populations suffered significant psychological morbidity after disasters.

Nature of the morbidity

Epidemiological studies show that about one third of the populations suffer from PTSD. The others suffer a wide variety of anxiety, depressive, and somatoform disorders. A range of disorders that is similar, but includes depressive and paranoid disorders, has been described in wartime civilian (Murphy, 1975) and combat (Brill, 1966; Lindy, 1988) populations. There has been little suggestion of specific stresses leading to specific disorders, though Paykel (1979) noted that exit losses were predictive of depression. Clinically, stresses are usually allowed at least a contributory role in psychiatric disorders generally, as noted in Axis IV in DSM-III-R (APA, 1987) and DSM IV (APA, 1994).

Also, there has been a stream of research associating cognitions and emotions with stresses and psychological illnesses.

Cognitions

Breuer and Freud (1893/1975) and Janet (1920) described both the "printing" of traumatic experiences on the mind and the mind's simultaneous "splitting of consciousness" (Freud) and "dissociation" (Janet) from these experiences. Both the reliving of the traumatic experiences and their suppression (Freud, 1920/1975), with the addition of later psychological defenses, constituted the core of neuroses. More recently, Horowitz (1976) described similar features of what he called stress response syndromes, although he explored further the importance of meaning and its processing in resolving these syndromes. Finally, the reliving and avoidance of traumatic experiences constitute the core of PTSD. However, as Weiner (1985) pointed out, it may also be a feature of other DSM diagnoses. Perhaps the content and the manner of reliving and avoidance determine these diagnoses.

Whenever traumatic situations leave room for ambiguity and choice, appraisals, as well as the passive searing of events that leaves no room for thought, become incorporated in traumatic stress responses. Appraisals of whether, and which, events were dangerous were called primary appraisals by Lazarus and Folkman (1984). These were vector results of sensory perceptions of reality and subjective meanings. A variety of factors, such as past experience, role, desire and perceived authority of those giving information, could feed into the subjective aspects of primary appraisals. According to Lazarus and Folkman, secondary appraisals then determined what strategies could be applied to deal with the stresses. Reappraisal involved processing the progress of the [illegible] avoidance and reliving

Emotions

Anxiety and depression have been noted commonly as stress responses. Pathological grief was considered as possibly associated with depression and physical illnesses (Raphael, 1984). Anger was noted in disaster and combat literature, and guilt was found in survivors of concentration camps (Krystal, 1968). Schmale (1972) described the "given-in/given-up" syndrome, which included hopelessness and helplessness. This syndrome was said to predispose to a variety of illnesses, such as cancer.

On the whole, however, it is striking that until the innovative efforts of Plutchik (1980), there were no attempts to classify emotions or to find a theoretical framework for them. This applied not only to the commonly described emotions such as anxiety, depression, anger, and guilt, but even more so to a great variety of emotions such as insecurity, contentment, power, and revenge. Panksepp (1989b) noted that the study of emotions has been assiduously avoided as unscientific, leaving a compulsory central lacuna in our understanding of the physiological and behavioral responses to stress.

Social Perspective

Perhaps because sociologists do not use an illness model, they have drawn special attention to people's capacities to cope through adaptive responses to stress. Further, they emphasize the positive aspects of family and community support (Quarantelli & Dynes, 1977).

Figley (1986) analyzed the factors in this support that acted as antidotes to stress disorders. They were emotional care, comfort, love and affection, encouragement, advice, companionship, and tangible aid. He also noted that the family and other helpers became vulnerable through their empathy, and could develop secondary traumatic stress disorders. It is now widely acknowledged that helpers are frequent secondary victims (e.g., Berah, Jones, & Valent, 1984). Mileti, Drabek, and Haas (1975) drew attention to the various system levels (individual, family, group, and community) that operate in disasters. Figley (1989) examined the family system in disasters.

The divisions among the biological, psychological, and social perspectives have been wide; for instance, each perspective has separate journals and institutional attachments. There has been some cross-fertilization—for instance, in biopsychosocial medicine (Engel, 1977). Another field has been that of strategies of survival.

Precursors to the Concept of Survival Strategies

Charles Darwin (1890/1965) noted that in order to deal with a variety of dangers, animals and humans evolved a variety of specific emotions

and behaviors. Cannon (1939), drawing on Darwin's observations, described fight and flight responses associated with the sympathetic nervous system.

Selye (1946) described a different physiological response to stress, which he called the general adaptation syndrome (GAS). This included secretion of the hormone cortisol, and suppression of the immune response. This physiological response does indeed facilitate adaptation (rather than fighting or fleeing stressors), but it cannot be considered a general stress response. In fact, the GAS is evoked in conditions of surrender (Blanchard & Blanchard, 1988; Henry, 1986b), and of the need for acceptance, as in bereavement (Irwin, Daniels, & Weiner, 1987).

Attachment, although not previously designated as a strategy of survival, is nevertheless a very important means of survival for the weak. As a biobehavior, it was first described by the Harlows (1965) in monkeys, and by Bowlby (1971) in humans. It has been described recently in many other species, as has its stressful opposite, separation (Panksepp, Siviy, & Normansell, 1985).

A number of recent developments has facilitated a more comprehensive approach to strategies of survival and their use as unifying concepts. First, evolutionary theory replaced the previous survival unit of the fittest individuals, by the breeding genes in a population (Wilson, 1982). This removed the apparent paradox of altruism, whereby the fittest often sacrificed themselves for weaker members. However, if through their actions greater numbers of group genes would survive, such altruism made evolutionary sense. Similarly, giving and taking (reciprocal altruism) could enhance group survival. This new evolutionary view allowed care of the weak and mutual cooperation to be potential SSs.

Second, advances in the study of animal behavior teased apart different survival behaviors that were previously under the single rubric of agonistic, or socially aggressive, behavior. Thus it was noted that postures of attack and sites of bites are quite different in predation (hunting), antipredator defense (self-defense, fight), and hierarchical struggles (competition). This finding meant that hunting, fighting predators, and competition could be three separate survival behaviors (Blanchard & Blanchard, 1988), each with its own type of aggression, anger, and physiology (Blanchard & Blanchard, 1988; Moyer, 1986; Olivier, Moss, & Brain, 1987; Shaikh, Brutus, & Siegel, 1985).

Third, emotions became a respectable field of scientific study (Panksepp, 1989b), because the use of complex new techniques such as computer digitization allowed them to be correlated for the first time with specific neurophysiological events and biobehaviors. The subjective self could now be correlated with objective data.

All these developments allowed propositions of relatively complex schemata of survival behavior, expanding the simple dyads such as fight and flight. Plutchik (1980) postulated eight specific survival behaviors, while Panksepp (1989a) postulated five survival "biobehavioral circuits." Although their approaches and semantics varied, these authors added four further potential survival biobehaviors to fight and flight: foraging (for food and water), attachment, grief, and sharing. Both authors emphasized the integral biopsychosocial nature of these survival behaviors.

Summary

Since Hippocrates' initial observations, it has been confirmed again and again that "the greatest changes, the violent alterations" may be "responsible for diseases." It is still difficult to conceptualize how this happens, and to know which disturbances may lead to which disorders. However, it seems possible that certain survival behaviors elicited in the circumstances of greatest changes and violent alterations (situations of traumatic stress) may provide vital clues that may make some sense of the variety of traumatic stress responses.

A number of leading workers have called for a theory that would connect and organize the vast array of available data. As noted, Mason (1968) almost 30 years ago asked for a taxonomy to organize his voluminous physiological data. Lazarus and Folkman (1984) said that even the most sophisticated (physiological) research might be sterile without a theory that included appraisals and emotions. Weiner (1989) concluded that there was a need to conceptualize the human response to particular stressors, and to link the highly complex neurochemical responses with tasks of survival. Panksepp (1986b) similarly called for a psychobiological theory that would demonstrate stress response patterns to be, in a deep sense, simple and logical.

It is suggested that SSs are important building blocks that help distill the volume of biological, psychological, and social data into meaningful, "simple and logical" patterns of biopsychosocial responses that serve survival. Survival strategies will be shown to be central concepts in delineating successful, adaptive, coping responses and unsuccessful, maladaptive, traumatically stressed responses. These strategies provide a framework for the variety of these responses, which is then applicable to both primary and secondary victims.

THE PLACE OF SURVIVAL STRATEGIES IN A CONCEPTUAL FRAMEWORK

Definitions

For the purposes of this chapter, a *stress* (Figure 1) is an event that disturbs the equilibrium of a person in such a way as actually or potentially to shorten the person's lifespan. *Appraisals* of the means of survival are cognitive processes that include sensory perceptions, past learning, and views of oneself, such as one's role and capacities. The appraisals evoke stress responses, which counter the noxious effects of stresses. They may be relatively simple instinctual responses, such as retrieval of balance or removal of body parts from painful stimuli. Survival strategies are stress responses of a higher level of complexity, including ideas, emotions, and social interactions. They will be defined further below.

Stress responses may be *adaptive* or *maladaptive* (Figure 2). Adaptive stress responses deal with stresses in such a way that life is not actually or potentially compromised. Maladaptive responses are either insufficient or the wrong ones to prevent actual or potential compromise of the lifespan. In such a case, other stress responses may be evoked. If these are not adaptive, strain, trauma, illnesses, or death occur. Both adaptive and maladaptive stress responses express themselves in a unified manner in *biological, psychological,* and *social* arenas. In fact, all the components being defined have such biological, psychological, and social aspects.

Strain is an unresolved tension between stresses and stress responses. *Trauma* occurs when stress responses fail to reestablish prestress life-enhancing equilibria. It is an amalgam of all the previous components. The situation in which trauma occurs is a traumatic situation. The stress that leads to trauma is *traumatic stress. Defenses* minimize the damage of trauma or its repetition. In the psychological arena, numbing and fragmentation in the early phase, and repression, phobias, displacement,

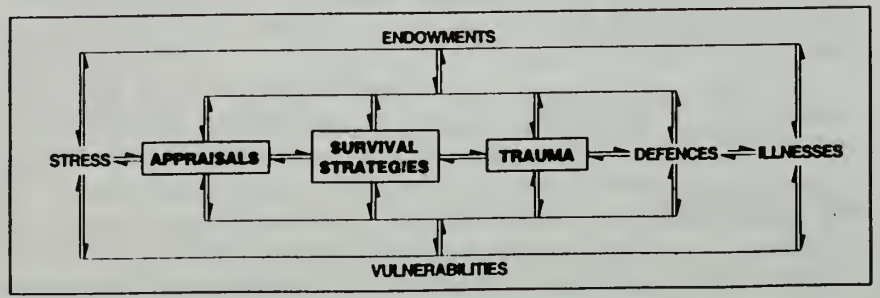

Figure 1. The place of survival strategies in traumatic stress

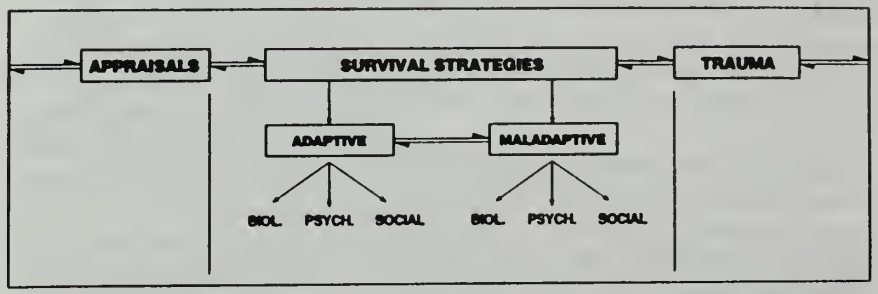

Figure 2. Survival strategies

and so on in the later phases, are examples of defenses. *Illnesses* may be defined as compromise equilibria following trauma. They include both the trauma, aspects of which are still relived, and the defenses against it. Symptoms are individual indicators of such compromise equilibria. It is suggested that illness seriousness is determined by the difference between pre- and post-stress equilibria, and that illness nature depends on the components of trauma, including survival strategies. Benefits occur when responses are adaptive and poststress equilibria are more life enhancing than prestress ones.

Throughout the whole process, *endowments* resist, while *vulnerabilities* facilitate, the noxious effects of stresses. For example, family may be a social strength, whereas isolation may be a social vulnerability.

Secondary traumatic stress (STS) responses occur when a person is secondarily influenced by the stress responses of another person. Components of stress leading to illness similar to those in Figure 1 become important in the secondarily affected person.

Let us now look at descriptions of SSs in more detail.

CHARACTERISTICS OF SURVIVAL STRATEGIES

The following features are suggested to characterize SSs.

1. *Evolutionary adaptedness.* The SSs are hereditary models present in humans and animals that have evolved to enhance the survival and perpetuation of evolutionary social units in the face of stressful situations.
2. *Level of operation.* Anatomically, SSs are intimately involved with MacLean's (1973) "old mammalian" brain—that is, the midbrain, limbic system, and primitive cortex—areas whose

role is to elaborate "emotional feelings that guide behavior with respect to the two basic life principles of self-preservation and preservation of the species." This area has rich, two-way connections with areas concerned with more primitive reflexes and instincts and with higher cortical levels.

3. *Biopsychosocial* (BPS). Each SS has integrated biological, psychological, and social aspects that act as functional units.
4. *Finite number with a multitude of combinations.* There is a small number of discrete SSs. However, they may occur in a wide range of combinations and proportions. For instance, a soldier whose buddy is killed may grieve, kill to exact revenge, or seek death in order to be reattached to his friend.
5. *Adaptiveness and maladaptiveness.* Survival strategies may be adaptive or maladaptive, and this may change according to circumstances. For instance, to choose continuation of combat in the face of massive enemy reinforcements may become maladaptive. Similarly, the previously mentioned soldier's combat skills may be affected adversely by his need to kill or be killed. When SSs are not adaptive, their subsequent continued intense replay and/or suppression may become components of trauma and lead to symptoms, disorders, and illnesses.
6. *Interpersonal effects.* Survival strategies may evoke identificatory or complementary SSs in others. For instance, another soldier's helplessness may evoke a complementary SS of rescue. In contrast, his surrender (to enemies, death) may elicit a similar SS in other soldiers through identification.
7. *Modulation of SSs.* In addition to physiological feedback, internal and external judgments of the appropriateness of SSs (reappraisals) modulate their actions. For instance, using the above example, the surviving buddy may reappraise his impulse to homicide or suicide through fear or internal admonitions, or other soldiers may put strong restrictions on his impulses. Often the reappraisals are in the form of severe moral judgments, such as, "You are going to get us all killed!" Without such monitorings, survival of self and others may be compromised.
8. *Higher-level symbolizations.* Survival strategies contribute to higher-level symbolizations, which include meaning, human values, and existential purpose. Thus the surviving buddy (and, later, his clinician) may have to struggle with the meaning of the buddy's death, the use of revenge, the point of human sacrifice, the morality of surviving, and the overall purpose of war and life and death. Not only sensory reminders of the original event, but cues relating to these dilemmas as well, may evoke SS responses from the original situation.

Evidence for the SSs that follow are derived from literature in the fields of anatomy, physiology, ethology, human development, psychology, sociology, and traumatic stress. Although of necessity biological, psychological, and social aspects of SSs are described sequentially, one must not lose sight of their integral functioning. In this chapter, the processes leading to appraisals are not detailed, nor are the many feedback systems and illnesses, important as they are.

The eight SSs are presented in Table 1. They may be considered as four complementary pairs of survival possibilities. The first line in each psychological and social cell deals with feelings and responses relating to one's own and others' physical selves. The second line deals with feelings and responses relating to distribution of resources. The third line (in italics) is a combination of the other two. In fight and flight, physical selves and resources merge.

Rescuers, helpers, and professionals may consider the responses listed in the table and the accompanying text as applying both to their patients or clients and to themselves. Thus both groups enjoy the satisfactions and fulfilments (even if initially at the cost of some pain) inherent in successful SSs. However, strained and maladaptive responses also apply to both victims and helpers, and ultimately so do trauma responses. Maladaptive responses in helpers may be seen as STS responses; the trauma responses noted in Table 1 provide a variety of primary and secondary traumatic stress disorder (STSD) symptoms. Helpers need to be wary when they experience STS responses, and they may well need actual help when they exhibit STSD manifestations.

What follows is a brief summary of SSs. A fuller review of their functions and ramifications will be set out in another work (Valent, in press). This will include ramifications of survival and fulfilment ranging from judgments and morals to human meanings, religion, ideology, and purpose.

Let us now look at each SS in turn.

THE SURVIVAL STRATEGIES

Rescuing–Care–Altruism

This SS is commonly evoked in disaster workers, and in medical and mental health professionals as they care for their charges. However, it is also evoked more widely, whenever it is clear that one needs to rescue, protect, or provide in order to enable others to survive. The paradigm

for such a one-way investment is maternal or parental care, an evolutionary survival milestone (Wilson, 1982) and one that differentiates later species from reptiles (MacLean, 1985). The SS subsumes nursing, nesting, protecting, retrieving and staying close (Rosenblatt, 1989), and maternal aggression (Troisi, D'Amato, & Camera, 1988). The provision of parental care is characteristic of all mammals, and of humans from all cultures. A biogram for this SS already seems to be present in young children who play at parenting, and who in dire circumstances may assume parental roles. Its evolutionary survival value lies in the preservation of the next generation and, thereby, the species. It also preserves the currently weak, who nevertheless may be useful in the future.

Hormonal studies on male parental behavior are not available (Capitano, Weissberg, & Reite, 1985), but dominant primate males do show almost maternal solicitude to infants, and they protect the young in their troops (Wilson, 1982).

Parental behavior may be exercised with regard to nonprogeny (such as through adoption) in higher vertebrates (Goodall, 1988; Wilson, 1985). In primitive societies, uncles often care for their sisters' children. Parental-type care may be offered even more widely (MacLean, 1985; Zahn-Waxler, Cummings, & Ianotti, 1986), even to needy adult strangers. This is commonly noted in disasters.

The SS is served by specific parts of the limbic system, with connections to the higher centers (MacLean, 1985). These areas are activated by female sex hormones such as estrogen and progesterone (Rosenblatt, 1989).

The adaptive mode of the SS is associated with feelings of care, empathy, devotion, and responsibility. When the responsibility is too great, and carers cannot cope, there is a sense of resentment toward the needy, a sense of depletion of one's own strained resources, and consequently neglect, and even rejection, of the unwanted burdens. Altruism turns to self-concern.

The failed SS in the traumatic state includes anguish and guilt for not saving life, or perhaps even contributing to death. This anguish is relived and avoided in traumatic stress symptoms.

Attaching

This SS is evoked when it is perceived that others are needed to effect one's survival by providing protection and satisfaction of needs. The paradigmatic situation is an infant attached to its mother. MacLean

TABLE 1
Survival Strategy Components

Appraisal of Means of Survival	Survival Strategies	Successful/Adaptive Responses			Unsuccessful/Maladaptive Responses			Trauma Responses	
		Biological	Psychological	Social	Biological	Psychological	Social		
Must save others	**Rescuing** Protect Provide	↓Estrogen ↑Oxytocin ↓Opioids	*Care Empathy Devotion*	*Responsibility Nurture Altruism*	Sympathetic & Parasymp Arousal	*Resentment Depletion Self-Concern*	Burden Neglect *Rejection*	Anguished Survivor guilt Caused death	
Must be saved by others	**Attaching** Protected Provided	?↑Opioids	*Yearning Need Contentment*	*Reaching out Crying out Union*	↑Opioids	*Abandonment Deprivation Aloneness*	Clinging Demanding *Separation*	Dread Cast out left to die	
Must achieve goal	**Asserting** Combat Work	↑E, NE ↓Cortisol ↑Immunocomp	*Strength High morale Potency*	*Will Success Control*	↓↑E, NE Depletion E, NE ↓BP, ?CHD	*Frustration Low morale Powerlessness*	Willfulness *Failure Lost control*	"Burn-out" "Learned helplessness"	
Must surrender goal	**Adapting** Accept Grieve	Parasymp Arousal ↑Cortisol	*Acceptance Mourning Hope*	*Yielding Loss Turn to new*	↓Cortisol ↓Immunocomp ↑Infection,↑CA	Helplessness Depression *Despair*	Overwhelmed Withdrawal *Given in*	Vulnerability Given up Succumbing	
Must remove danger	**Fighting** Defend Rid	Symp Arousal ● ↑NE, E ↑BP	*Threat Revenge Fighten*	*Deterrence Wounding Riddance*	↑↑Symp Arousal ↑Cortisol	*Hatred Persecution Killing*	Attack *Eradication Destruction*	Horror Evil Murder	
Must remove oneself from danger	**Fleeing** Retreat Save oneself	Symphathetic & Parasymp ↑ Arousal	*Fear Terror Deliverance*	*Hiding Flight Escape*	NE Depletion ↑E & Cortisol	Phobia *Paranoia Engulfment*	Avoidance Panic Annihilation	"Inescapable shock," being hunted, killed	
Must obtain scarce essentials	**Competing** Struggle Acquire	↑Testosterone Symp arousal	*Winning Possession Power*	*Dominance Privilege Take*	↑Testosterone ↑Female horms ↓Cortisol	*Greed, envy Crushed*	Submission Plundered *Empired*	Terrorization Marginalization Elimination	
Must create more essentials	**Cooperating** Trust Mutual gain	↓Opiates ↑BP, E, NE	*Mutuality Generosity Creativity*	*Reciprocity Shaning Synthesis*	↓Opiates ?↑Parasymp Arousal	Iden w aggr *Exploited Stagnation*	Appeasement Robbed *Disintegration*	Alienation Fragmentation Decay	

(1985) considers the evolution of attachment concomitant with maternal care, with which it is reciprocal, and which it evokes.

Attachment promotes psychobiological synchrony (the mother's capacity to modulate the infant's physiological and psychological responses). Thus attachment preserves vulnerable progeny and gives a solid base for future life. Failure in this area may compromise short- and long-term integrated physiological and psychosocial function (Coe, Lubach, & Ershler, 1989; Reiter & Capitano, 1985).

The biological concomitants of secure, contented attachment are not known. However, the emotions of separation and abandonment may be processed by parts of the hypothalamus and the cingulate gyrus (Panksepp et al., 1985), and may be associated with low levels of internal opiates. The administration of opiates reliably suppresses the crying out (distress vocalizations) of separation in all tested species (Panksepp, Meeker, & Bean, 1980).

In adaptive attaching, crying and reaching out lead to appeasement of yearning and satisfaction of needs. Union with an attachment figure gives a sense of security and contentment. Maladaptive attachment is experienced as abandonment, deprivation, and utter aloneness. Yearning, clinging, and demanding may become desperate, with a high level of separation anxiety. In the traumatic state, separation is associated with a dread of having been cast out to die. Van der Kolk (1987) suggests that the loss of the secure base that attachment provides leads to some of the well-known manifestations of the trauma response.

Attachment also may be directed toward fathers and other members of the group, and may be active in all adults who feel vulnerable. Society provides attachment figures in government and in religion. Attachment ideation, in which an important figure is imagined to be present, may help survival in dire circumstances.

Rescuers and helpers do not use this SS as a matter of choice. However, when their own superiors do not support them, or when through their own needs they attach themselves to their clients, maladaptive attachment responses may become evident. For instance, carers may feel anxious without their clients and may cling to them to an extent beyond that beneficial to the clients.

Assertiveness (Goal Achievement)

This SS is evoked by the appraisal that one must achieve certain goals to survive. The paradigm for this SS is hunting, though forces of nature may symbolize wild animals. We may forget that hunting has been a

major feature of the human species for the first 99% of its evolutionary existence (Washburn & Lancaster, 1977). Laughlin (1977) notes that hunting has been the master behavior pattern of the human species, directing the evolution of the human body, technology, and society. Hunting's derivatives in the modern world are work and combat. They serve the need to obtain food and shelter (essential goals), and to control the environment in order to do so. The force used in this SS is often confused with violence in fight. However, "aggression" in this SS is called "instrumental" (Olivier et al., 1987), that is, "without affect," as when a cat kills a mouse quietly and efficiently.

The SS is served by specific parts of the midbrain and limbic system (Shaikh et al., 1985), and it is associated with arousal of the sympathetic nervous system, with secretion of epinephrine (E) and norepinephrine (NE) (Dienstbier, 1989; Ursin, Baade, & Levine, 1978). Immunocompetence, the capacity of the immune system (the cells and antibodies that deal with bacteria, viruses, and cancer cells), is enhanced, whereas cortisol secretion is suppressed (Dienstbier, 1989; Henry, 1986b). These physiological responses are the opposite of those described by Selye (1946) for the GAS, and those found in the next SS. The depletion of E and NE is cushioned by a sense of control and confidence in success (Dienstbier, 1989), whereas NE depletion (a hallmark of traumatic stress in flight as well) occurs in animals that have learned that they cannot control pain (Weiss, Stone, & Harrell, 1970).

Goal achievement is associated with feelings of strength and of one's will prevailing, high morale, potency, and control. Failure is associated with frustration, demoralization, powerlessness, a sense of loss of control, and exhaustion resulting from continued effort. Extremes of these responses have been described in the traumatic state of "combat exhaustion" (Bartemeier et al., 1946), and may be part of the syndrome of "burnout." The responses also resemble those in "learned helplessness" (Abramson, Garber, & Seligman, 1980), where there is repeated failure to achieve goals. Van der Kolk and Greenberg (1987) have speculated that this also may be part of the trauma response.

Combat exhaustion and compassion fatigue may overlap to some extent in the different contexts of the army and the helping professions. Certainly, burnout occurs in both, and is characterized by the fatigue, frustration, and powerlessness associated with the inability to achieve goals. Learned helplessness may be the long-term outcome of trauma involving this SS. Degrees of burnout are common in rescue teams (Berah, Jones, & Valent, 1984) and in helping teams such as those dealing with very ill patients in hospitals.

Sustained maladaptive assertiveness may contribute to the Type A

personality, and to hypertension and coronary heart disease (CHD) (Appels & Mulder, 1989; Henry, 1986b; Van Doornen & van Blokland, 1989).

Adapting (Goal Surrender—Rolling with the Punches)

This SS is evoked with the appraisal that old goals must be surrendered to new ones. The paradigmatic situation is having to accept a major loss, and to grieve it. The grieving process may be a relatively new evolutionary adaptation; its precursors are present only in several species, such as birds (Lorenz, 1968) and primates (Goodall, 1988), and weeping is characteristic only of humans. Nevertheless, mourning rituals are found in all cultures. We may speculate that this SS provides a buffer zone for recuperation and readjustment to new circumstances.

The anatomical substrate for this SS probably includes the hippocampus and septum, and it is mediated by the parasympathetic, rather than the sympathetic, nervous system (Henry, 1986b).

As Selye (1946) noted, there is increased activity of the pituitary–adrenocortical axis, with increased cortisol secretion. In humans, this response is already present in infants, for example, just prior to delivery and after circumcision (Joffe, Vaughn, & Barglow, 1985). In bereaved adults many studies show increased corticosteroid activity (Irwin et al., 1987; Wolff, Hofer, & Mason, 1964), and diminished immunocompetence (Bartrop, Luckhurst, & Lazarus, 1977; Calabrese, Kling, & Gold, 1987). Both arise in proportion to the lack of denial and presence of distress and depression in the bereaved subjects (Irwin et al., 1987). Diminished immunocompetence may lead in turn to diminished resistance to inflammation and tumors in monkeys (Coe et al., 1989) and humans (Calabrese et al., 1987).

The psychosocial readjustment in adaptation is yielding, accepting and mourning loss, and then turning in hope to a new future. In the maladaptive situation, people feel overwhelmed and helpless, withdraw into depression and give in to despair. In the traumatic state, they have given up, their vulnerability is fully exposed, and they succumb. Succumbing to overwhelming stress has been a common view of trauma.

Helpers may themselves be overwhelmed and despair of being able to help. This is frequently seen when devastation is great, traumatic bereavements have occurred, or patients have been diagnosed with an incurable disease or are dying. Helpers need to accept death and destruction, and their own limits and vulnerabilities. Inability to accept loss often leads to inappropriate exhortations to "cope," to "not cry." At worst it can lead to denigration of victims and callousness in helpers. Helpers will ultimately also need to grieve the loss of their charges as they become self-sufficient.

Fighting–Defending

This SS is evoked by the appraisal that one is being attacked, and so must defend oneself and be freed of the threat at any cost. The paradigmatic situation is that of being attacked by a predator—animal or human—and the evolutionary function of the SS is to deter or eliminate such attacks.

Deterrent threat postures described by Darwin (1890/1965) are similar in all vertebrates (Blanchard & Blanchard, 1988) and all cultures. They are naturally present in children, including the deaf and the blind (Henry, 1986b). The amygdala and the hypothalamus seem to be associated with fight (Blanchard & Blanchard, 1988). As Cannon (1939) pointed out, there is arousal of the sympathetic nervous system. NE secretions are increased, especially that of NE, when the response is especially directed and aggressive. Clinically, the heart rate and blood pressure are elevated (Henry, 1986b). Cortisol secretion may increase, but only in the short term (Leshner, 1983). Although often reported as raised in male aggression, testosterone is raised mainly in competitive aggression (Blanchard & Blanchard, 1988). In fact, castrated animals can fight well against external danger, although they compete poorly against their own kind (discussed later). The physiological responses of this SS are sometimes seen as the markers of PTSD (Friedman, 1991).

If threatening postures and vocalizations are not sufficient deterrents, inflicting damage on the enemy in proportion to one's own actual or potential (as yet small) wound is used to signal to the enemy that it is "a tooth for a tooth, an eye for an eye, a life for a life." This talionic principle is accompanied by a feeling of seeking revenge and may deter attack or a further attack. If these defensive maneuvers of adaptive fighting fail to frighten off the enemy, defense becomes attack and is associated with "affective aggression" (Kling, 1986)—that is, hatred and a desire to kill. Maladaptive fighting includes persecution, eradication, destruction, and killing on a large scale. The traumatic reaches of this SS involve violence, murder, and atrocities, with later horror at the evil of the killing.

The traumatic reliving of this SS among Vietnam veterans has recently drawn much attention. It is uncommon in helpers, although it is advisable to be aware of hatred and the desire to be rid of patients and clients who have come to be perceived as threats.

Fleeing

This SS is evoked by the appraisal that it is essential to escape from danger—paradigmatically, predators, but also natural disasters. When

distancing is impossible, the animal may hide or make itself small (Henry, 1986b) and "freezes,"—emitting low-aggression-releasing cues to others. Animals and humans in such situations may also "cut off"—avert their heads from the source of attack, and close their eyes and ears (Dixon & Kaesermann, 1987), as well as their minds. Flight is a ubiquitous SS in animals and humans of all ages and all cultures. It is common during disasters and wars.

Flight is served by parts of the hypothalamus, amygdala, and midbrain (Henry, 1986b). It is also associated with activity of the sympathetic nervous system, though E, NE, and cortisol ratios vary from those with other arousal SSs, and the parasympathetic nervous system may be active as well. This demonstrates that it is not only the physiological markers that may distinguish different SSs, but also their different combinations and ratios.

Adaptive flight is associated with feelings of fear and terror, which turn to relief and a sense of deliverance with escape. When escape is blocked, panic may set in, with a sense of persecution and incipient engulfment and annihilation. Alcohol and benzodiazepines (e.g., Valium) may diminish engulfment anxieties (Dixon & Kaesermann, 1987).

In the traumatic state, the organism senses that it is being hunted and is about to be caught and killed. Van der Kolk and Greenberg (1987) suggest that the inability to escape aversive events ("inescapable shock") may be relevant to the trauma response. It is associated with NE depletion in the chronic state (see also "Assertiveness"). Panksepp (1986a) draws attention to the fact that flight symptoms are common components of startle responses, nightmares, and phobias (as also noted in PTSD). Phobias and paranoia may be symptoms of reliving prior terrors of being "hunted" and engulfed.

Helpers may themselves feel the need to escape the stressors that affect their charges. They may also become fearful of their clients and their own responsibilities for them. In either case, helpers may find rationalizations for escaping their involvements. Premature withdrawal of services is common, the usual excuse being lack of funds.

Competing

This SS is evoked when one appraises that one must obtain scarce resources before others do. The paradigm is a contest for food. In early evolutionary theory, the fittest were seen to win such struggles more frequently, leading to their "natural selection" and differential survival (Scott, 1989).

It is now clear that it is more adaptive, safe, and economical for animal communities to establish hierarchies, which then determine the distribution of scarce resources, than for all to struggle against all others each time. Status in hierarchies is determined by prior (nonlethal) ritualized contests (Wilson, 1982). Hierarchical competition (pecking order) is ubiquitous among social animals and in primitive cultures (Lienhardt, 1966). It is present in toddlers by the age of two (Cummings, Hollenbeck, & Iannotti, 1986).

Competition for status among males, or "social aggression," has been studied the most physiologically. High status is reflected very sensitively in high levels of sex hormone levels, especially of testosterone, and this is constant across species (Knol & Egberink-Alink, 1989; Mazur, 1983). In humans, even winning or losing a tennis match is reflected in testosterone levels (Booth, Shelley, & Mazur, 1990). Defeat is associated with low levels of testosterone, as well as of female sex hormones, and increased levels of the "adaptation" hormone cortisol (Henry, 1986b; Leshner, 1983).

Interfemale competition may be facilitated by testosterone, as well as by female sex hormones (Henry, 1986b). The medial hypothalamic sites that selectively take up testosterone seem to be involved in competition.

In a situation of scarce resources, winning a dominant position is adaptive because it confers privileged access to and possession of food, sex, shelter, and comfort. Power also gives the privilege of taking the largest share and then distributing the rest down the hierarchy.

When competing is maladaptive, defeat and submission may become self-perpetuating, with new challenges being met with increased levels of corticosterones and compromised immunocompetence (Fleshner, Laudenslager, & Simons, 1989). The confident efforts in high-status individuals, in contrast, are facilitated by high testosterone, E, and NE levels (Henry, 1986b).

When hierarchies break down, a struggle for resources ensues. Ordered distribution fails, greed and envy take over, and the strong plunder the weak. The defeated may be crushed and emptied, and in traumatic situations the weak may be terrorized, marginalized, and finally eliminated. This is where the classical evolutionary notion of all struggling against all, and survival of the fittest is most appropriate.

Those who continue power struggles without winning may be vulnerable to hypertension and infections (Jemmott, 1987), while defeated and dejected Type A personalities (those constantly struggling against deadlines and other people) may be predisposed to CHD (Appels & Mulder, 1989).

Helpers may become agents and advocates in the competitive strug-

gles of victims, and may use their status and influence to effect better distribution of resources. However, helpers may also compete among themselves for status and leadership within their own groups, or access to clients, funds, and research greater than those of other helping groups. At worst, victims themselves become a resource to compete for and use, rather than help.

Cooperation–Affiliation

This SS is evoked when it appears necessary to become a trusting partner with others to create mutual essentials. The biological paradigm is procreation. Cooperation has been present in evolution since protozoa (Scott, 1989), and its function is to preserve and increase the community's gene pool.

When reciprocity is not immediate, the initial giving may be seen as altruistic. Trivers (1971) called this "reciprocal altruism," because in a community such giving is reciprocated over time. Reciprocal altruism is found in animals and humans. All cultures have customs of giving and taking, and mutual obligation. Even babies share—they take and hand back (Eibl-Eibesfeldt, 1980). Such activity establishes bonding or a "social glue" (Youniss, 1986).

Social bonding is associated with parasympathetic responses such as decreases in blood pressure, pulse, and E and NE secretion (Henry, 1986b). Sexual activity and social bonding involve the amygdala and temporal and orbital cortices (Steklis & Kling, 1985)—the precise areas highest in mu-like opiate receptors. We may speculate that opiates attach to these sites, enhancing a sense of social comfort, while their withdrawal intensifies a sense of social need. We may further speculate that external opiate drugs may be used to attempt to simulate the calm of social bonds.

In nature, adaptive cooperating—as seen, for instance, in postdisaster euphoria—is associated with the emotions of trust, mutuality, generosity, reciprocity, sharing, and love. Its outcome is creativity and synthesis. When the SS is maladaptive, there is initially identification with, and appeasement of, the noncooperating partner. This is akin to identification with the aggressor (i.e., paradoxical gratitude, pathological transference, the Stockholm Syndrome as noted by Ochberg [1988]). However, feelings of being betrayed, exploited, and robbed emerge. There is a sense of stagnation and disintegration in place of synthesis and creativity. In the traumatic state, there is a final sense of alienation, decay, and falling apart.

Cooperation, generosity, and cohesiveness are commonly noted in

traumatic situations (Turner, 1967). Social support is recognized as ameliorating traumatic stress (Figley, 1986). Maladaptive cooperation, however, exacerbates traumatic stress. Jemmott (1987) found that affiliative personalities were relatively protected from high blood pressure and had better immunocompetence than did controls.

Helpers themselves may become imbued with a surge of generosity and giving, which is reciprocated with gratitude by those helped. Cooperation between victims and helpers may lead to creative solutions. If the expected generosity or gratitude is not forthcoming, there may be disappointment and a sense of being exploited or betrayed. The previously creative mutual helping process may stagnate or disintegrate.

Judgments as an Example of the Applications of SSs

We can see that different SSs evoke qualitatively different stress responses. However, as mentioned above, they are also associated with the foundations of higher-level ramifications, of which judgments are one example. Judgments may be conceptualized as one form of psychosocial feedback (reappraisal) on the functioning of SSs. One type of judgment, let us presume, is "right and wrong." Communication of right and wrong includes anger and guilt, both of which are commonly noted in association with traumatic stress. We may say that anger is a feedback judgment on the maladaptive nature of others' SSs, while guilt is a judgment on the maladaptive nature of one's own SSs. The two interact and may fluctuate. Anger and guilt may themselves be adaptive or maladaptive. Let us see how SSs may allow us to refine and understand the various angers and guilts associated with different SSs.

- *Rescuing*. Helpers may feel wrath toward victims who do not accept help, or who may even put helpers into hazardous situations by their actions, such as people who refuse to evacuate burning houses. Alternately, rescuers feel survivor guilt for not doing enough to save others.
- *Attaching*. Those who feel abandoned protest angrily or assume guilt for having displeased their attachment figures. ("Why?!" and "Why me?!" are expressions of anger relating to another judgment—justice—and express the injustice of being "punished" even if one has been good.)
- *Asserting*. The anger here stems from frustration when thwarted, and the guilt is that of failure.
- *Adapting*. Anger is at others' lack of support; guilt is for not missing the lost person.
- *Fighting*. Fury is felt toward a threatening object, but guilt for mur-

der facilitates adaptive fighting.

- *Fleeing*. The anger is felt toward hindrances to escape, while the guilt is for endangering the self and others by being stuck.
- *Competing*. There is outrage at the threat to one's status, which may be balanced by priority guilt for improper precedence over others. These responses facilitate the establishment of an adaptive hierarchy.
- *Cooperating*. There is anger with a straying partner and the guilt of betrayal.

A fuller exploration of judgments is presented elsewhere (Valent, in press).

DISCUSSION

It seems that SSs could help to provide a meaningful psychobiological framework for the variety of contradictory biological, psychological, and social responses in traumatic situations. Their biopsychosocial nature, their fluctuations according to circumstances, combinations of SSs in different permutations and proportions, together with the "culture" and phases of specific traumatic situations and the people in them, account for the richness of traumatic stress responses. Understanding SSs can help to understand the nature, reason, and manner of production of traumatic stress responses.

It is also suggested that SSs provide an important part of a framework for understanding the components and connections between stresses and illnesses. They help to establish a framework for appraisals and stress responses, whether adaptive or maladaptive, biological, psychological, or social. They set up a framework for the multitude of stress responses and help to give them sense and purpose in terms of the survival of one's self and others. They help to explain the beneficial effects of stress. Survival strategies are also trauma and illness components, and as such they help us to understand the nature of trauma and some of the reasons for particular illness symptoms. Thus SSs are useful to a theory that tries to meet the stress-leads-to-illness paradigm.

With regard to a theoretical view of traumatic stress, it is suggested that PTSD may be seen as the umbrella concept that indicates how traumatic stress responses are reexperienced and avoided. On the other hand, SSs describe what is reexperienced in disorders and why. Therefore, SSs supplement the wealth of the concept of PTSD. They also suggest that what have been variously designated as core aspects of trauma may be the traumatic states of different SSs.

Objections may be raised against delineations of certain SSs. On the whole, however, SSs correspond well to the survival behaviors described by Plutchik (1980) and Panksepp (1989a). Certainly, opinion is consistent about the existence of a relatively small number of discrete basic survival behaviors. Some differences are semantic, and the ultimate honing and naming of SSs may depend on further research in various disciplines.

What was said about the SSs is even more applicable to their components. There are a variety of physiological, and emotional and social, nuances that are difficult to capture in one or two words, and indeed need to be altered for slightly different situations. This area requires further exploration.

The specificity of SSs may be questioned. For instance, in the physiological area, some chemicals (E, NE, cortisol, opioids) are present in more than one SS. However, as Panksepp (1986b) tells us, it is likely that nature performs its usual economies by using the same chemicals for different purposes. As noted above, physiological profiles and proportions may matter at least as much as the actual chemicals. It is here that the study of appraisals and emotions is particularly useful, since subjective explanations of feeling and intention may crystallize meaning to a myriad of measurements.

Applications of the SS Framework

Clinical Application

The conceptualization of SSs is ". . . in a deep sense, simple and logical . . ." (Panksepp, 1986a) in promoting an understanding of traumatic stress responses. The responses make sense in terms of PTSD symptoms too, as SSs from the traumatic situation still being relived and avoided. Therapeutically it may provide great relief to victims to define the source and function of a variety of their responses that may initially seem irrational to them.

Further, the responses and symptoms themselves may give clues to the specific SSs evoked in the original traumatic stress situations, and help recover them and their contexts if they have been unprocessed or forgotten. Even judgments, moral conflicts, and struggles with existential meanings may give clues to the nature and context of SSs in the original context.

Last, the concurrent biological, psychological, and social natures of SSs draw attention to concurrent biological, psychological, and social dysfunctions. This enhances more comprehensive treatment.

As an example, the soldier whose friend was killed may present years later as a Vietnam veteran who evidences periods of depression, suicidal behavior, and outbursts of aggression for no apparent reason. He may

also be deeply cynical about society and his own worth, and physically may suffer violent headaches and be hypertensive. Each of these end symptoms can be traced back to the original traumatic stress(es). Then each can be explained and treated in a meaningful way, not only as a symptom, but in the context of the original trauma.

Research

Survival strategies have opened a new window of opportunity to investigate the meaning of physiological, psychological, and social responses to stress. They make it possible to validate more clearly the intuitive understanding that separation distress, grief, arousal to fight, and so on have different physiological and psychosocial associations. On the one hand, one can study more clearly the associations of a "pure" SS. On the other hand, one can clarify the significance of responses by knowing which SSs are being evoked at the time. This may be determined by knowing the subjective state of the person's appraisals and emotions (Panksepp, 1989a). This knowledge may be quite important even in simple experiments such as an examination, because the stress may evoke a number of SSs, such as assertiveness, competition, flight, and acceptance.

Toward a Framework for Emotions and Social Actions

It may be said that Table 1, which lists emotions and social responses according to SSs, provides a framework for those responses and denotes their significance and function. For instance, depression is associated with maladaptive (impacted, unresolved) grief. We may speculate that the illness depression may contain this emotion, as well as other maladaptive and traumatic features relating to adaptation (mitigated by defenses). Depression (and defenses) may obscure the initial traumatic situation.

Note that anxiety does not appear in Table 1. It is a less specific emotion, applicable to each SS, but with different overtones in each, akin to anger and guilt as described earlier. Thus I suggest intuitively that the anxiety of, say, being caught and killed (flight) is different from the anxiety of killing someone. If this were not so, global anxiety would prevent the choice of any specific SSs. Also the traumas associated with each SS are associated with the ultimate dreads of humankind, and each feels somewhat different.

Further, while anxieties that arise during SSs are functioning as negative feedback signals and may be called ego anxieties, the anxieties that arise in response to negative judgments may be called superego anxieties. The anxieties of using the wrong SS may be called id anxieties. Each of these anxieties is a little different. In researching anxiety, it is important to know which anxiety is being considered.

Secondary Traumatic Stress Responses

People's SSs influence not only those with whom they share a current traumatic situation, but also those who try to ameliorate its later effects. This group includes family, emergency workers, and helping professionals. The interactive nature of emotions and actions in SSs may help to explain the ubiquitousness of STS responses. The mechanisms of STS may be described in the following.

Identifying with and Experiencing Victims' SSs

Empathizing with and being devoted to victims opens the helper to feeling all the maladaptive SSs and traumatic responses of victims. Hence the initially adaptive identification and understanding of victims may lapse into the helper's becoming a fellow victim.

Responding to Victims' SSs with Own SSs

The emotions and actions of victims may evoke a complementary (or another) SS in helpers. For instance, conveying a sense of a helpless dread of death or of anger at being abandoned (attachment cues) may evoke care and responsibility, or potential guilt for causing harm, in a helper, and elicit a rescuing SS. Ideally the appropriate adaptive SSs are elicited—that is, those that help rectify victims' maladaptive ones.

However, the SSs evoked in helpers may be maladaptive too. This may happen if the helpers themselves are overburdened or are inadequate to the task. Another difficulty may lie in helpers' misinterpreting victims' responses as belonging to the present, instead of understanding that the victims are reenacting their traumatic situations (transference). In either case, helpers may respond with inappropriate SSs. For instance, they may retreat (flight) in the face of victim anger, or they may care too much because of their own guilt.

Survival strategies enable helpers to define their own responses and understand them in the context of their involvements with victims. This could be considered as using countertransference.

Secondary Traumatic Stress Disorder

From this perspective, when helpers cannot execute their own SSs adaptively, their unsuccessful maladaptive SSs (that is, their traumatic stress reactions) may deteriorate into STSD. For helpers, rescuing and asserting are commonly used SSs. So when not coping, helpers may come to feel, respectively, burdened, resentful, rejecting, and guilty; and frustrated, demoralized, not in control, exhausted, and "burned out."

Associated with STSD, they may feel judgments of guilt such as survivor guilt and guilt for failure and incompetence. They may also suffer the different angers and anxieties of these SSs.

STSD, like STS responses, can also develop through intense identification with victims' maladaptive and traumatic responses, and intense inappropriate eliciting of a variety of inappropriate helper SSs.

Helpers need to identify the variety of STS responses and STSD symptoms they experience, and integrate them into debriefing meetings or into counseling and therapy. And those involved with helpers may themselves be affected in the same way as the helpers and become tertiary victims.

Wider Applications

Because trauma is situated between life and death, health and illness, normality and abnormality, it occupies a crucial place for humans. It may not be death, as much as it is trauma, that provides the feared counterpoint to life. As such, it ramifies all aspects of life. We already noted trauma's presence in the biological, psychological, and social fabric; in various moral judgments; and in different social groupings. We noted that trauma is symbolized in morality, justice, values, meaning, and purpose. To examine these aspects in any depth requires much future exploration. However, such research is necessary to fully understand the extraordinary scope of trauma in human existence.

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Section B:
The Impact of Victimization on Families

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Panelists:

Diane Litchfield
A survivor of domestic violence
c/o MOVA
1 Ashburton Place, Suite 1101
Boston, MA 02108
(617) 727-5200

Liam Lowney
Brother of a homicide victim
c/o MOVA
1 Ashburton Place, Suite 1101
Boston, MA 02108
(617) 727-5200

Sharon Simone
A survivor of child sexual and physical abuse
c/o MOVA
1 Ashburton Place, Suite 1101
Boston, MA 02108
(617) 727-5200

Bette Spear
Executive Director
OMEGA Emotional Support Services, Inc.
8 Harris Street
Malden, MA 02148
(781) 321-5040

Coordinator: **Brooke Ely**

Executive Summary

THE DAVID and LUCILE PACKARD FOUNDATION

The Future of Children

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DOMESTIC VIOLENCE AND CHILDREN

Domestic Violence and Children

ANALYSIS

Today, domestic violence, defined as violence between adult intimate partners, is recognized as a serious societal problem in the United States. Researchers estimate that between 3.3 million and 10 million children are exposed to domestic violence each year, and that this exposure can have significant negative effects on children's emotional, social, and cognitive development. These effects may include:

- Aggressive behavior and other conduct problems;
- Depression and anxiety;
- Lower levels of social competence and self-esteem;
- Poor academic performance; and
- Symptoms consistent with posttraumatic stress disorder, such as emotional numbing, increased arousal, and repeated focus on the violent event.

Studies of children's resilience in the face of community violence and war reveal that the most critical protective factor against the negative effects of child exposure to violence is a relationship with a competent and caring adult. In instances of domestic violence where one parent is the victim and the other parent is the perpetrator of the violence, parents may be unable to meet their children's needs. Because the battered parent can be a critical support for the child, and because children often have ongoing contact with the batterer, domestic violence services must be made available to help parents improve interactions with their children.

Many families in which domestic violence is present struggle with multiple problems including poverty, substance abuse, and exposure to other forms of violence, such as child maltreatment. For example, in 30% to 60% of families experiencing either domestic violence or child maltreatment, the other form of violence is also present.

Families experiencing domestic violence utilize the services of health care, child protective services (CPS), mental health, and law enforcement agencies, as well as the courts and community-based domestic violence programs. Current services reach only a small percentage of children exposed to domestic violence, and are typically not designed with the specific needs of these children in mind. Promising new programs for children exposed to domestic violence exist in each system, and emphasize collaborative, cross-agency service provision and training.

Federal and state policies in a wide range of areas affecting families may have an impact on children exposed to domestic violence. At the federal level, these policies include recent domestic violence, welfare reform, and child welfare legislation. Policies at the state level include:

- Criminal sanctions for perpetrators of domestic violence;
- Judicial authority to issue civil protective orders that prohibit a perpetrator from approaching the adult victim, the children, and their home, school, or workplace;
- Child custody and visitation laws for divorce cases; and
- Child protection policies that determine when CPS intervention is indicated, and the nature of that intervention.

Little is known about the effectiveness of current policies and programs in improving outcomes for children exposed to domestic violence. Despite the limitations in current research, the potential harms of child exposure to domestic violence necessitate action shaped by the best information currently available, and new research that improves the present knowledge base.

RECOMMENDATIONS

RECOMMENDATION 1

Research is needed that advances the current understanding of the prevalence and effects of childhood exposure to domestic violence, and the impact of resilience and risk factors, so that policymakers and practitioners can design interventions that sufficiently address the size, nature, and complexity of the problem.

RECOMMENDATION 2

Stable public funding sources are needed to support comprehensive and coordinated community-based services for battered women and their children, as well as program evaluations and replication of effective interventions.

RECOMMENDATION 3

Because the majority of children exposed to domestic violence do not have access to services through traditional avenues such as battered women's shelters, new strategies for identifying and serving these children in other venues, such as health care institutions, must be developed.

RECOMMENDATION 4

Child protective services and domestic violence service organizations must develop clear protocols for intervening with families in which both domestic violence and child maltreatment are present, and these protocols should offer services that provide safety and stability to the child, support to the battered woman, and treatment and sanctions for the batterer.

RECOMMENDATION 5

Professionals who have regular contact with families and children, including teachers and child care workers, health and mental health care providers, law enforcement officers, child welfare workers, and court personnel should receive ongoing training related to domestic violence and its impact on children.

RECOMMENDATION 6

Courts must be empowered to design and enforce protective orders that comprehensively address the safety needs of battered women and their children. All battered women must have access to affordable legal counsel, so that they can utilize available legal means to protect themselves and their children.

RECOMMENDATION 7

In child custody and visitation cases involving domestic violence, courts should consider in their analysis the best interests of the child and the potential impact on the child of ongoing exposure to parental conflict and violence.

RECOMMENDATION 8

In designing new laws to address the effects of childhood exposure to domestic violence, policymakers should assess the potential unintended negative consequences of these laws and weigh them against the benefits.

RECOMMENDATION 9

Ongoing public support is needed for effective prevention programs that address the underlying causes of domestic violence.

ARTICLE SUMMARIES

Prevalence and Effects of Child Exposure to Domestic Violence

John W. Fantuzzo, Ph.D., and Wanda K. Mohr, Ph.D., R.N., F.A.A.N.

Presently there are no scientifically credible estimates of the national prevalence of children exposed to domestic violence. Nonetheless, existing data suggest that large numbers of American children are affected. And, though research examining the effects of child exposure to domestic violence is also limited by methodological problems, there is sufficient evidence to conclude that such exposure has adverse effects. The specific effects may differ depending on the children's ages, the nature and severity of the violence, the existence of other risk factors in the children's lives, and whether the children are also directly physically abused. In general, childhood exposure to domestic violence can be associated with increased display of aggressive behavior, increased emotional problems such as depression or anxiety, lower levels of social competence, and poorer academic functioning. A scientifically credible body of research on the prevalence and effects of childhood exposure to domestic violence is vital to the development of effective interventions. This article identifies some of the steps that can be taken to build the research capacity necessary to obtain the needed data.

The Impact of Violence on Children

Joy D. Osofsky, Ph.D.

Existing research on the effects of children's exposure to violence covers a broad range of community, family, and media violence. This research is relevant and useful to an examination of domestic violence in two key ways. First, understanding how exposure to various types of violence affects children and what best enables them to cope, can inform approaches to helping children exposed to domestic violence. And second, many families experiencing domestic violence are exposed to other types of violence as well. Exposure to violence on multiple levels can affect the parents' behavior, and compound the effects on children. This article begins with an overview of the extent of children's exposure to various types of violence, and then reviews what is known about the effects of this exposure. Protective factors for children exposed to violence are also examined. Research indicates that the most important protective factor is a strong relationship with a competent, caring adult, most often a parent. Yet, when parents are themselves witnesses or victims of violence, they may have difficulty fulfilling this role. In the final section, directions for future research are discussed.

The Impact of Federal and State Laws on Children Exposed to Domestic Violence

Martha A. Matthews, J.D.

Until recently, few federal and state laws specifically addressed the needs of children in families in which there is domestic violence. Yet, many laws, particularly in the areas of domestic violence, family law, child welfare, welfare reform, and immigration, can have a profound impact on the well being of these children. Policymakers' growing understanding of the potential harms of domestic violence to children has resulted in recent years in statutory changes, particularly at the state level. However, laws that are enacted and implemented with inadequate knowledge of the complex dynamics of domestic violence and the unique issues battered parents and their children face, may have unintended negative consequences for the children these laws are designed to protect. Collaboration across public and private social service agencies and domestic violence training for court personnel can bridge this knowledge gap and increase the likelihood that the protective intent of the laws is carried out in practice. This article analyzes current and proposed federal and state civil laws in order to better understand their potential impact on children affected by domestic violence.

The Legal System's Response to Children Exposed to Domestic Violence

Nancy K.D. Lemon, J.D.

Historically, the legal system has not responded adequately, if at all, to cases involving domestic violence. In the past two decades, courts and law enforcement agencies have increasingly acknowledged the seriousness of domestic violence and developed responses to it. Unfortunately, the legal system has been slow-

er to recognize the impact of domestic violence on children. This article highlights four key areas of case law in which the courts have begun, in varying degrees, to examine the effects of domestic violence on children: child custody and visitation, restraining orders, failure to protect a child from harm, and termination of parental rights. A survey of appellate cases since 1990, though not representative of all cases, shows an ongoing need for mandatory judicial training on domestic violence and its effects on children, greater clarity about how to interpret relevant laws, changes in the laws to better serve children, and the renewal of national funding for legal aid programs. Courts and law enforcement agencies in some locales have implemented innovative programs to improve their interventions with children exposed to domestic violence. These programs include coordinated court responses, child development training for police officers, multidisciplinary team approaches, and supervised visitation centers. However, few of these programs have been evaluated for overall effectiveness in improving outcomes for children. Better evaluation is needed, as is ongoing funding for the replication of successful programs nationwide.

Child Protective Services and Domestic Violence

Janet E. Findlater, J.D., and Susan Kelly, M.S.W.

Studies indicate that domestic violence is present in at least one-third of the families involved in the child protective services (CPS) system. Yet, until recently, CPS has not directly addressed domestic violence in its handling of child abuse and neglect cases. By the same token, domestic violence programs have historically emphasized services for battered women, with limited understanding of the child safety goals of CPS. Despite these historical differences, collaborative efforts between CPS and domestic violence service programs are emerging based on a common goal of safety from violence for all family members. Innovative strategies include the use of domestic violence specialists in a variety of child protection settings for case consultation and for support to the battered women; direct referrals of battered women from domestic violence programs to family preservation services; and cross-training of CPS workers and domestic violence service providers. A survey of state CPS administrators and domestic violence coalition directors conducted for this article revealed that, though there is mutual interest in greater collaboration, such efforts remain limited. Critical to successful strategies are supportive agency leadership, greater understanding across systems, a recognition of common goals, and a willingness to change policies and practice.

Community-Based Domestic Violence Services

Amy J. Saathoff and Elizabeth Ann Stoffel, J.D.

Community-based domestic violence services have expanded their range of programs since their emergence in the 1970s. In addition to crisis-oriented services, such as telephone hot lines and temporary shelter, many of these agencies provide legal, health, mental health, or vocational services, and assistance in finding housing and planning for safety. Most recently, in response to increasing knowledge about the deleterious effects of child exposure to domestic violence, community-based service providers have developed programs addressing children's mental health, health, educational, and safety needs. This article concludes that, whereas there has been significant growth in community-based domestic violence services for children, substantial segments of the target population still are not reached, and the range of services is not sufficient to meet children's diverse needs. Nonetheless, there are promising new directions in service delivery, including community outreach efforts and collaborative approaches with other agencies concerned with children's welfare. These developments suggest that future years will see continuing progress by community-based organizations in addressing the needs of children exposed to domestic violence.

Health Care System Responses to Children Exposed to Domestic Violence

Patti L. Culross, M.D., M.P.H.

The health care system has only recently adopted protocols and provided training to enable practitioners to identify and respond to victims of domestic violence. Currently, most hospitals have domestic violence protocols in place, although training in the use of protocols is less routine. However, because the provision of health care focuses on the treatment of the individual, the well-being of the children of adult domestic violence victims has received little attention in adult health care settings. Pediatricians do not routinely receive training in domestic violence and do not see responding to battered mothers as within the purview of their practice. Innovative programs in children's hospitals in Boston and San Diego recog-

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3

Murder and the Family System

This chapter reviews the special factors relating to the family system of someone who has been murdered. In general, caregivers and researchers have offered little recognition of such situational factors that affect co-victims. There is, for example, an insignificant body of research and literature that differentiates among the various influences on family members in the aftermath of a homicide. It is important, therefore, to look more in depth for the commonalities, the similarities, and the differences that situational factors within the family suggest and to consider *all* members of a co-victim's family in plans for recovery.

Common responses of co-victims and generalizable themes exist, although in varying degrees of intensity, regardless of the circumstances of the murder. The most frequently reported responses include isolation, grief, loss, stress, anger, blame (for both victim and self), guilt, denial, need for revenge, shock, betrayal, and emotional regression. The most important themes that need to be considered

include feelings of being ignored and excluded by the criminal justice system and victim advocates, the infliction of second wounds, and disenfranchised grief.

In most murders, any extenuating factors will elicit significantly distinct responses from co-victims concerning each person's experience of trauma, grief, and ability to cope. Situational factors do not fit into discrete categories and may even overlap, putting co-victims into a number of different categories at the same time. The more situational factors that affect co-victims, the more difficult it becomes for caregivers and service providers to help them reconstruct their lives.

The Uniqueness of Family Loss

After a murder, the family unit undergoes permanent changes that are hard for the surviving members to accept. Family dynamics will obviously be affected if for no other reason than that there is now a different number of people in the family. For example, after a murder, it is often confusing when someone asks, "How many children (or siblings) do you have?" Many people say that they hesitate while they search for the right answer and often do not know what to say.

Some co-victims may wish to protect other family members. This role of the family protector usually falls to the father, although not exclusively so. The bereaved one who assumes this role may not pay attention to his or her own pain and grief while trying to assist with and even divert other family members' pain and grief.

> My family had suffered a wound almost as mortal as my daughter's. Yet I was in no position to offer more than a Band-Aid. My family was drowning and so was I. (Mother of a murdered child)

Unfortunately, the members of the family network—parents, children, cousins, aunts, uncles, and so on—are usually incapable of providing each other with emotional support because they all have varying degrees of exposure to the murder and closeness to the victim. Possibly, one witnessed the murder, another found the body, and yet another barely knew the victim. Therefore, the time frames for grieving and recovery vary accordingly (Pynoos & Nader, 1990).

How a person copes with the murder of a loved one can be highly influenced by family rules and coping mechanisms. Haran (1988) has noted a number of typical family patterns: (a) death and conversations about death are taboo, (b) someone must be to blame, (c) things must go on as before, and (d) all must function with openness and a sharing of feelings.

To provide appropriate interventions, caregivers will need to understand distinct familial subsystems—parents, spouses, children, siblings, significant others, and extended family—within the context of the unique victim to co-victim relationship of each. The issues of intrafamily homicide, including pedicide and domestic violence, are also important.

PARENTS

Parents represent the largest group of co-victims by relationship. The term *child*, as used here, refers to a relationship, not an age. The death of a child is rated as the most stressful life event (Sehnert, 1981) and puts parents at high risk for complicated mourning. Rando (1993) states that "when compared to other types of bereavement, parental mourning is particularly intense, complicated, and long-lasting, with major and unparalleled symptom fluctuations occurring over time" (p. 611). The sudden, traumatic, and arbitrary nature of a child's murder even further complicates the grieving process. Being the parent of a murdered child predisposes the co-victim to posttraumatic stress responses.

The death of a child is outside the natural order of life.

The death of a child is outside the natural order of life. Children are supposed to outlive their parents; parents are not supposed to bury their children. As Rando (1993) points out, there is no word in the English language to define a parent whose child has died, as there is to describe a person whose parents have died (orphan) or whose spouse has died (widow/widower). The issues and emotions are the same whatever age the child because they revolve around the loss of

the relationship. Regardless of the age of the child, the parents' role vis-à-vis the victim is abruptly broken. Parents can feel that they have lost their legacy and their immortality. The grief and mourning process must be examined in light of any developmental issues that were present in the parent-child relationship at the time of the murder.

When told of the murder of their child, irrespective of the victim's age, parents cry out, "My baby! My baby!" Many parents have reported seeing the image of their newborn or very young child in their arms, rather than a picture of the child at the time of the murder. To many parents, the vision of the baby symbolizes the responsibility they felt, often in the form of a silent or whispered promise to care for and keep the child safe from harm. This can lead to self-blame and guilt.

> Fairy godmothers are not distributed equally, but the same witch appears at every birth. Her gift is vulnerability: once delivered into the world no child is ever safe again. Parents know this. That's why they're forever yelling: "Don't touch!" and calling the pediatrician and fretting when the baby doesn't finish his bottle. That's why they turn deaf ears when their children beg to walk to school alone, go to the store alone, play in the vacant lot on their way home. That's why parents are such terrible pests. ("The girls who had everything," 1986, p. A30)

Parents often fear for the safety and innocence of their surviving children. In certain inner-city neighborhoods, it is not uncommon to find that some families have had several children murdered in separate incidents. Parents may become overprotective, causing friction as children wish to become more independent.

> After our 8-year-old son was abducted and murdered, we educated Christie at home from the time that she was 10 years old until she went to college. We couldn't bear to let her out of our sight. (Parents of a murdered child)

When an adult child is murdered, many may negate the level of the parents' grief. Others may verbalize thoughtless and cruel comments such as, "At least you must have a lot of good memories to comfort you." The toll on the parents' emotional state is even more complicated if a child's actions are perceived by others to be contributory to his or her death, such as if the child is a prostitute or drug dealer.

Parents of a murdered child are often demoted to the outsider circle of mourners, with the spouse and children of the victim being the primary recipients of attention from family, friends, and the criminal justice system.

> The parents of a 33-year-old man read about his death in the local newspaper the morning after it occurred. Their daughter-in-law was arrested for killing their son. Even though the two families only lived five blocks apart, the police never notified [the parents] of their son's murder, telling them later that they considered his wife to be the next-of-kin. (A victim advocate)

Stepparents

In today's society, the duties of parents may often be shared with stepparents. These individuals may be ignored, or their anguish may be assumed to be less. Many stepparents have had long-standing relationships with and feel deep affection for a murdered child. They, too, will grieve. On the other hand, because they are not the biological parents, the relationship has likely existed on a different plane. The stepparent is often able to step back and offer a level of support to a spouse that the birth parent is not capable of providing. Having to deal with former spouses can greatly increase the stress of parents who have divorced and remarried. Some caregivers feel that reunions should be encouraged, but this may also add to the anguish of the spouses.

Grandparents

Grandparents constitute another group of family members whose feelings are often overlooked and ignored. In the contemporary United States, an increasing number of grandparents are raising grandchildren whose own parents are unavailable because of divorce, illness, drug use, or other family problems. Rando (1993) states, "When grandparents have been involved intimately in family life, they are like bereaved parents of a second order" (p. 181). Many

grandparents feel that they suffer two losses. "They not only lose the grandchild they loved, but many feel the loss of their own child, the parent who is changed so radically by the murder" (NOVA, 1985, p. 4).

Seeking Justice

> Life's parents said that they "were very pleased" with the death sentence but had mixed emotions. "I feel sorry for the [defendant], I feel sorry for his family. But I feel sorry for my family," said Theodore Life. "I miss my son. I wish he was here."
>
> "This was the ultimate justice. But it's not going to bring back my son," said Renee Life. "The pain is going to last for a long time, for the rest of our lives." (Loyd, 1994, p. B5)

Many parents are prepared to go forth—each in his or her own way—and do battle against the murderer of their child. They may even work together, attempting to bring some control back into their lives.

From a demographic standpoint, women outnumber men in the bereaved parent group, and mothers are more likely to become the family member who is responsible for calling or visiting the police, the prosecutors, or the media in the search for answers or justice. The majority of police and homicide detectives are men, however, and there are more male than female prosecutors. The result is that mothers often receive a second wound from the system, a gender-related wound that does not extend to fathers. The insensitive, and often patronizing, way some individuals are treated by the system may deter some, but this treatment often has the opposite effect on mothers by making them more resolute in their efforts.

Implications for Research

The new class of bereaved parents of young victims will have responses that are not typical of other parental bereavement. The lack of an appropriate model that addresses both the variables affecting the mourning process and specific interventions for caregivers increases the likelihood that co-victims will receive assistance that may

be more hurtful than helpful. More research is also needed to determine the long-range implications of the murder of a child. This has not been explored to any great extent because only in the last 20 years have bereaved parents of homicide victims been recognized.

SPOUSES

The death of a spouse is rated by many sociologists as one of the most stressful changes that one can experience in life (Sehnert, 1981). When this death is also sudden, traumatic, and violent, the surviving spouse faces many additional issues that are not usually well understood by others, including caregivers; furthermore, the new class of spousal co-victims is predominantly young, female, and African American, not the traditional widow or widower whose spouse has died after a long illness. In addition, co-victims of all ages and socioeconomic backgrounds, including common-law partners, have had spouses who were killed during another crime, such as a robbery.

> It was supposed to be their first Christmas together and David Atlas wanted to make it memorable for his new wife, Mary Rose. . . . But for everyone who knew Atlas, this Christmas has turned into a tragedy. . . . "It's unbelievable that something like this can happen so quickly," said Mary Rose Atlas, 25, as she wiped away her tears. . . . "I never got a chance to be by his side and say goodbye. And then to hear that he died so violently . . . ," she said, her voice trailing off. (Laker & O'Dowd, 1993, pp. 4, 5)

Caregivers need to fully understand the grief process, the isolating nature of widowhood, and the unique stresses surrounding the violent death of a spouse that add to the great void in a person's life. First of all, the recently widowed spouse must learn new tasks and skills, regardless of the cause of death. There might also be a significant loss of identity. As Rando (1988) states,

> For most of us, our relationship with our mate is . . . a central part of our self and our being in the world. As a result, one of the major roles your spouse had was as someone who affirmed your identity. (pp. 127-128)

The loss of identity seems to be more problematic for women than for men, even if they are employed outside the home. If the spouse died violently, the interactions with the criminal justice system and the media will add greatly to the list of a widow's responsibilities, which unfortunately cannot be found outlined in a how-to book.

> We were building our life together. We were working to get a mortgage and everything. (Daughen, Costantinou, & Sheehan, 1994, p. 22)

Often, a spouse is considered a partner's best friend as well as lover. On the other hand, if a marital relationship is troubled at the time of a murder, there may be residual feelings of guilt and anger. If the co-victim blames a murdered spouse for certain behaviors that the co-victim feels may have contributed to the murder, the anger is exacerbated. This blame can be extended to behavior as innocuous as being in the wrong place at the wrong time or working late.

The anger associated with blame often covers up other emotions that may be too difficult to deal with, especially in the early stages of the grief process. Anger may be present in any case—anger at being left alone to deal with all the responsibilities, such as child rearing, that were formerly shared in the marriage and that are now greatly increased as the result of the murder.

CHILDREN AND TEENAGERS

Children who are the co-victims of homicide are the most forgotten co-victims. Their needs tend to be overlooked because they cannot always speak for themselves. Reliable statistics are not readily available regarding the numbers of these children, but on the basis of the demographics of murder, there seems to be agreement that the number is growing. This discussion refers to co-victims under the age of 18 as children, unless their developmental stage is of particular interest to the discussion at hand.

There are two main categories of child co-victims: (a) those who are indirect victims because a parent, sibling, friend, or classmate has been murdered, but the child was not a witness; and (b) those who have directly witnessed the homicide of a relative, friend, or stranger.

Indirect Co-Victim Issues

The extent to which violence reaches U.S. children can be seen in a study of inner-city elementary and high schools, in which more than 70% of the students reported having witnessed the robbing, stabbing, shooting, or killing of another person (Bell & Jenkins, 1991, p. 2). Today, with the increase in the homicide rate of young African American men in the inner city, African American children in the inner cities are most likely to have had a sibling murdered, with the murder of a parent being the second most murdered relative. It is not unusual for children in the inner city to have had more than one family member murdered.

Parents may feel ambivalent about whether to discuss the death and their own feelings with their young children. They also wonder whether to allow a child to attend the funeral. Many researchers believe that well-developed children aged 3 to 4 are able to understand the basic meaning of death. Parents or primary caregivers should decide whether the child will attend any services but with the child's input regarding the decision. In later years, children who were not included in the funeral often carry a great deal of resentment and feel that they missed a significant passage in their life. Children can and should be included in activities such as creating a memory book and planning memorial services or special commemorative events (e.g., a school assembly and planting a tree or flower garden for their loved one). These projects allow them to get involved and feel a part of what is going on.

Children and teenagers may feel isolated and withdraw from the family unit.

Children, especially the younger ones, who have had a parent murdered may have an overriding concern about who is going to take care of them after the murder. This fear may be profound if the murder leaves a child an orphan. It is important for adults to allow children to vent their feelings. Because children tend to talk sporadically about the event, adults need to be ready to give their attention when children bring up the subject of the murder. Such discussions should not be put off until some later time because children may stop

talking about it altogether. Adults need to give them permission to do this without being judgmental. As Beckmann (1990) notes, conversation between parents and children is important because it gives children permission to grieve.

Both young children and teenagers tend to feel isolated after a murder and may withdraw from the family unit as a result. When parents talk about what they themselves are going through, children are apt to feel left out. Some children pull back because they do not wish to see their parents further upset. But parents need to be aware that a flat affect coupled with the avoidance of any discussion of the deceased could indicate a problem. They should not assume that the child is doing fine and does not need any special help or support.

Teenagers typically do not want to talk about the murder. Adolescent children often feel their parents are not willing to talk about what happened, while, at the same time, the parents may feel their teens simply do not care.

> Whenever we mention Lloyd's name, both our children [aged 13 and 15] either make faces or get up and walk out of the room. They don't ever want to talk about him; it's as if they never had another brother. So we've stopped mentioning Lloyd's name in front of them. (Parents of a murdered child)

Direct Co-Victim Issues

Children who witness violence directly may be particularly traumatized. They frequently exhibit post-traumatic stress symptoms and other extreme reactions. Such stress may actively interfere with children's ability to reminisce or otherwise reduce the emotional resources available to them throughout the grieving process. The extent of stress largely depends on the type and amount of support available to these children and the ways in which the family interacts as a result of the murder. Traumatized children are typically haunted by intrusive images of the violence, recurring traumatic dreams, and a preoccupation with revenge fantasies. They may withdraw socially, act emotionally constricted, lose interest in their normal activities, and perform poorly in school. These children are also at

greater risk to perpetrate violence as they grow older (Pynoos & Eth, 1985).

Child co-victims must be provided with assistance and services regardless of whether they are exhibiting symptoms or signs of distress. Children who witness a murder *will* be affected by this event throughout their lives, and it is best to address the issues as soon as possible. The potential costs of the multigenerational legacy of trauma that could occur if this group of co-victims is neglected are staggering in both the short-term impact on the children and the long-term impact on society.

ADULT CHILDREN

The homicide rate for older adults is much lower than for young people—67% of murder victims are younger than the age of 35, whereas only 33% of the victims are over 35 (MacKellar & Yanagishita, 1995, p. 4). Nevertheless, this category of co-victims is no less important. Yet this group receives insufficient attention because of the presumption that older adults are experiencing part of the natural order of life and, therefore, that the situation is more acceptable and easier to bear. Research relating to the violent death of a parent and the resultant impact on an adult child is almost nonexistent.

Regardless of many erroneous assumptions, the death of a parent is still a critical life passage. If married, adult children may have mistakenly assumed their primary emotional relationships would be with their own family. Many adult children are surprised at the intensity of the emotions they feel at the death of a parent. In addition, sufficient support may not be forthcoming from other family members and friends who may not recognize the degree of pain and grief that is experienced by the bereaved.

A number of factors will affect the grief and bereavement of an adult child when the parent dies, regardless of the cause of death. Rando (1988) provides a good overview of problems that adult children face when a parent dies. The violent, sudden murder of a parent, however, does not comfortably fit within those parameters. The shock and trauma exacerbate all the known issues and raise many additional responsibilities for which the adult child is not prepared. For example,

- Adult children may not recognize how much their identity is tied up with that of their parents and their own role as the child. They may experience a profound change in many familial relationships after the death of a parent.
- The death of a parent forces adult children to look at their own mortality.
- The quality of the adult child's relationship with the parent influences the grief process.
- The age and life circumstances of a parent affect the level of grief. If a parent is still enjoying a quality life, the death of the parent will always seem untimely.
- An adult child's age and period of development are also important to consider, along with whether the parent was the first or second parent to die.

> I am left feeling like an orphaned child, although my father is still alive. My mother was my "constant." I'm left without a place to belong. My mother was the person that held my family together. Without her, all seems unbalanced. The most important person in my life is gone!! The loss and pain are so deep. I feel like I [am] drowning, like eventually I'll just lose consciousness and die. I've never felt so alone. Even in a room full of people who love me I feel alone. (Daughter of a murder victim)

Not only must adult children deal with the ramifications of the untimely death of a parent, but also they may take on significant new responsibilities such as going to the medical examiner's office, dealing with the criminal justice system and the media, and taking care of a surviving parent and other family members. Adult children may also have many competing interests and obligations that greatly add to their stress level. The combination of these factors and insufficient support and acknowledgment can make them question their own capacity to tolerate this event.

When a sibling is murdered, the most common emotion is guilt.

SIBLINGS

When a sibling is murdered, the most common emotion is guilt. The surviving sibling's guilt is especially strong if there was an argument immediately preceding the murder. Young children think that somehow their thoughts have caused the murder. In addition, because their bereaved parents are grieving so intensely, some children may believe that their parents loved the deceased sibling more than themselves.

Adult Siblings

Many adult siblings cannot remember a time when their other sibling was not there. Some adults consider that their sibling is their best friend. Even if they are now grown and living in different households and no longer maintain a close relationship, these siblings are still connected by strong familial ties.

Adult siblings often find themselves serving as a buffer between other family members, the system, and even society. The trauma and grief they experience after a murder can be quite devastating and may go unrecognized by family and friends. For example, bereavement leave from work may be minimal, certainly less than might be allowed the parents of a victim. Or the spouse of a co-victim may not understand the depth of grief for a sibling because the spouse did not have the same bond with the deceased. As a result, the need of adult siblings for help and support is rarely met.

Because of the high rate of homicide of those aged 15 to 24, increasing numbers of young adults have had a sibling murdered. Although they share the same emotional responses, adult siblings are often more ignored and forgotten than younger siblings. Their pain and confusion compounded by lack of acknowledgment, adult siblings perceive that they are relegated to a secondary role as mourners and do not receive the permission they need to fully experience their grief (Doka, 1988).

In the aftermath of a homicide, a sibling may often be asked, "How are your parents doing?" Condolence cards, notes, and memorial contributions are usually directed to their parents, and rarely does anyone inquire about the sibling.

> After Danny was killed, everyone flocked to my parents. I felt very alone. At night my parents got to go to bed together; if one of them cried, the other was there to hold them. I went to bed by myself. It was

> the most lonely time in my life; I can't imagine ever feeling that lonely again. (Sibling of a murder victim)

Many adult siblings, predominantly men, articulate their desire to take revenge for the murder of a sibling. Some of them even form elaborate plans for doing so, although few actually carry out their plans. The revenge fantasy, at least the articulation and the planning of it, seems to be most common to this co-victim group. Sometimes, plans are made in concert with other siblings and may include the father. Most parents are fearful of such thoughts of revenge, however, because they envision the loss of other children to imprisonment or death as a possible consequence.

> The defendant accused of murdering my daughter was acquitted at his trial. After the trial, my sons, Bob, 32, and Ron, 37, came and told me that they were planning to go to Florida [where the murder occurred and the man still lived] and kill him. I really wanted to see the man punished, but I didn't want my sons to have his blood on their hands. I begged them not to carry out their plans for a year and then see how they felt about it. My sons never went to Florida as far as I know, and they never mentioned it to me again, and I didn't bring it up either. (Mother of a murder victim)

Changing Familial Roles

The murder of a sibling will alter the entire family system. Parental reactions to adult children will change; this in turn changes the responses of the surviving siblings. Each may seek to protect the other, no one revealing his or her true feelings.

> I thought it was my job to protect them. They would cry when I cried, therefore I tried not to cry in front of them, then I broke out in hives from the stress. Doctors told me not to do that anymore. (Sister of a murder victim)

After the murder of a sibling, familial roles can undergo major transformations. Adult siblings can find themselves taking care of their parents, both physically and emotionally, making decisions for them as well as nurturing and protecting them. Sometimes, this role reversal is unsolicited and unwelcome, which can aggravate an already strained parent-child relationship due to stresses brought on by the murder.

> After Marlene's 20-year-old daughter, Rachael, was murdered in a holdup, Marlene requested to view the pictures of her daughter at the death scene. She wanted to see her face at the time of death. Her other son, Michael, aged 30, contacted the prosecutor who was handling the case and told him not to allow his mother to view the pictures. Michael felt that his mother would get too upset and he didn't want to have to deal with that. Marlene was in good health, understood the possible emotional consequences of looking at the pictures, and had made her decision based on her own needs. The prosecutor barred Marlene from seeing the photographs as a result of Michael's request. Marlene felt angry, frustrated, and that she was being treated like a child by both Michael and the prosecutor. Not only were Marlene's needs not met, but she was resentful of her son's intervention, which she had not requested nor did she feel was necessary. (A victim advocate)

Adult children may view the death of a sibling in an egocentric manner and feel bereft and abandoned as do young children. Feelings of anger and resentment may also surface as adult children deal with changing familial roles. It may be necessary for them to learn to reconstruct their relationships with their parents, and they may do so only with great reluctance. Most adult children prefer their parents to maintain their former roles. Looking at their parents' vulnerability or viewing them as unique individuals, independent of the parental context, can be disconcerting (Frogge & Cantrell, 1991).

> I've never seen my dad smile the way he used to—it's different now. (Sister of a murder victim)

Integrating these changes is not an easy task for parents either, especially without some form of professional guidance. The murder may trigger other family issues that have never been resolved, such as parental divorce, various configurations of family and sibling estrangement, and other issues related to loss.

It may occur to siblings that their order in the family has been affected; the middle child may now become the oldest child. The birth order has not changed, but the way they are perceived by their families may have changed. They may feel that they need to assume

a new role, although other family members may not agree. For the sibling who has become an only child as the result of a murder, feelings of isolation and loneliness may be greatly exacerbated. The remaining sibling may feel, and rightly so, that no one else truly understands his or her pain, or even makes an attempt to do so.

The family system will be affected as siblings renegotiate their individual and collective roles and as unresolved issues resurface. Depending on the relationship between the sibling and the deceased sibling, both in the past and at the time of the murder, the grief process can vary greatly from sibling to sibling.

BEYOND THE IMMEDIATE FAMILY

Although the immediate family of a murder victim may feel the greatest impact from the death, others experience its effect as well: Friends, significant others, and extended family members may feel the loss as deeply or, under certain circumstances, even more deeply. The victim may have lived far from family members and learned to rely on friends and colleagues as a surrogate family. Or, perhaps, a family estrangement may have led to the strengthening of other nonfamilial relationships. Employed adults spend the majority of their waking hours at work, where they often develop strong friendships. In addition, extended family members such as aunts, uncles, and cousins may have had a special bond with the murder victim. The strength of such relationships and the great pain these people feel when their loved ones are murdered are well articulated in the following paragraph.

> It took away my friend and also part of me. Although I have a family, I miss her, I feel as though my life is empty. I still can't believe she's dead. I cry a lot even while working, or on my way to and from work. I'm alone a lot more often than I used to be, preferring to be by myself than with others. We were like sisters. She and I shared everything—dreams, plans for the future, and so forth. (Best friend of a murder victim)

These mourners are also co-victims, but their status is often misunderstood or denied. They too suffer from what Doka (1988) refers

to as "disenfranchised grief," and they may not feel that they have permission to grieve (p. xv). Someone may remark to such a co-victim, "What are you so upset about?" Co-victims feel even worse when they do not receive the necessary acknowledgment and support from others around them. Caregivers, members of the criminal justice system, and even victim advocates may not think to include or invite this group of co-victims to court proceedings or support groups or to offer them any standing in the case.

Significant Others

The term *significant other* can be applied to a number of relationships, including fiancé(e)s, live-in partners, and gay or lesbian partners, who are all relegated to the position of secondary mourners. They are left to believe that their pain can be considered only after that of the more immediate family. It is often wrongly assumed, especially by blood relatives, that their relationship is less significant than that of other family members. Furthermore, these relationships may not have met with the approval of certain family members.

Friends and family may presume that because the co-victim was "only" a significant other, he or she will more easily find a replacement relationship. These loved ones, however, are unlikely to simply forget the victim and "move on" with their lives as though nothing has happened.

> There were times when I believed that I wouldn't get through it, I felt that I would never meet anyone else, I didn't want to meet anyone else. I never wanted to fall in love again. (Significant other of a murder victim)

The family of the victim may exclude significant others in the funeral or memorial arrangements. At the services, they may be left to sit by themselves. The family may even perceive the presence of significant others as an intrusion and may resent their involvement on any level.

Co-victims may have no idea where to turn for help. They may not even fully comprehend the depth of their despair, which could stem from a lack of acknowledgment. The co-victim may feel uncomfort-

able in going to a support group, especially if the family of the victim also attends. Mental health professionals may not be supportive either because they may not fully comprehend the repercussions of the co-victim's loss.

Socially Forbidden Relationships

Other significant others include those who are engaged in extra-marital affairs or in a gay or lesbian relationship with the murder victim at the time of the death. According to Fowlkes (1990),

> In the socially forbidden relationship of an extra-marital affair, special stigma is attached to the "other woman [or man]." . . . Secrecy obscures the ending of such a relationship socially just as it obscured its existence. There is no satisfactory outlet for the expression of loss and grief. (p. 645)

The trauma, the loss, and the grief are thus complicated, which makes the mourning "perhaps the loneliest and potentially most destructive grief of all" (p. 644).

The co-victim of a gay or lesbian homicide victim is affected in a similar way. Whether or not others know, the relationship will still be stigmatized by some, which will affect the co-victim in the aftermath of the murder. If the relationship is a secret, the partner may be excluded from the funeral—and from interactions with the criminal justice system, which may seriously impair the criminal investigation. If the victim was killed in a violent incident related to sexual orientation and the blame placed on the victim, and through the victim to the co-victim, the empathy and support offered to the co-victim will be lessened.

> "I always believed that it was a matter of harassment, not life and death, that it was something that happened to gay men, late at night, outside of seedy bars," she said. "I always thought that life-endangering oppression happened to people different than [*sic*] me. To heal, I had to acknowledge the world as a place that includes the possibility of getting shot and killed at any moment." (Lesbian lover of murder victim, quoted in Weiner, 1995, p. G4)

If the relationship is not publicly acknowledged or condoned, then public mourning will not be condoned either. These co-victims may be expected to continue their daily lives as if nothing had transpired.

Coworkers

In many instances, employed adults consider their coworkers as surrogate family members. Today's workplace environment, which includes the extensive use of work teams, fosters the formation of close relationships. Grief in the workplace has received little attention from human resources departments and employee assistance programs. Developing protocols to deal with the problem is not considered a priority, although mourning after a loss must occur for a person to heal. The emotional ups and downs of mourning may be considered verboten in the workplace, particularly if it negatively affects job productivity, increases sick leave, and leads to increased workers' compensation claims. Stein and Winokuer (1989) state that

The murder of a fellow employee triggers many strong emotions.

> the vision of man as a machine is diametrically opposed to human needs. This kind of work experience fosters an environment in which the expression of feelings is taboo. In the norms of the world of work, all losses then become disenfranchised because emotions and feelings are discounted, discouraged, and disallowed. The exception to this unstated rule is loss due to death. However, even mourning as it relates to death is severely constrained by narrowly defined policies that govern acceptable behaviors. (p. 93)

When a violent death of a colleague occurs, whether in or out of the workplace, most employers are clearly not prepared to deal with it. The murder of a fellow employee triggers many strong emotions in the other employees, including past issues that have not been resolved.

> If I was working . . . I would have hit the murderer with a chair or grabbed her from behind. I wouldn't have let her take my friend away

> from me. If I had gotten shot also, well so be it. (Friend and coworker of murder victim)

A murder in the workplace, whether or not coworkers have been actual witnesses, is certain to lead to an increase in workplace problems. In this worst of all scenarios, it is important to provide special services, for example, the creation and training of a team to conduct a critical incident stress debriefing. This fairly new intervention model allows caregivers to respond quickly whenever a coworker is murdered, regardless of whether the event occurred at the work site or elsewhere (see Chapter 6, "Interventions and Advocacy").

Because there are few mechanisms within the work setting to acknowledge and deal with emotions, the granting of time off for bereavement may be left to the discretion of a supervisor. Any policies on bereavement leave are usually qualified by relationship, which does not often cover absence from work for coworkers or colleagues of the victim. An exception may be for coworkers to attend the funeral or to pay a condolence call to the family of the victim.

Whether formal or informal bereavement policies are in place, they do not begin to take into account the manifestations of grief that appear later in the continuum of mourning. In addition to group crisis intervention, coworkers, who are co-victims, will benefit from services such as peer support groups, referrals to victim advocate agencies and other community resources, and participation in memorial services or scholarship funds.

> Companies need to provide training in grief to both managers and employees. For managers this training will provide the information necessary to understand the grief process. . . . For employees it can be a road map through a difficult time. (Stein & Winokuer, 1989, p. 99)

In dealing with a homicide in the workplace, the manager or supervisor may also be grieving and may not be in a position to be helpful. Education in the grief process will need to be offered so that both employer and employee can better understand the added dimension of the trauma of a homicide as well as the grieving process.

❑ Intrafamily Homicide

Intrafamily homicide is quite complicated for all parties concerned: the co-victims, the criminal justice system, and the caregivers. The majority of intrafamily homicides involve domestic abuse and child homicides, leaving behind many co-victims. In 1993, 12% of all victims were known to be related to their assailants (Bastian, 1995, p. 3).

COMPLICATIONS OF HOMICIDE IN THE FAMILY SYSTEM

The murder of a loved one by another family member exacerbates all the issues that affect co-victims of homicide. Furthermore, the stresses of an intrafamily homicide may destroy any semblance of family, at least as it existed before the murder. In addition to the trauma, grief, and bereavement issues, there are many other complex family system and legal issues, such as custody, property matters, and concerns with social security payments. It is not uncommon for the family to end up in criminal court, civil court, or both, locked in an adversarial stance.

Each of the many co-victims within any given family has experienced a different relationship with the victim and the perpetrator. The family is often sharply divided by individuals' responses to the event and the manner in which they grieve. Thus, familial relationships may be irreparably damaged.

> Stephen Raymond, a 72-year-old retired physician, murdered his 33-year-old daughter after a family argument. He had a wife and nine other grown children. Mrs. Raymond and eight of the children took sides against the father. Only one of the children maintained contact with Dr. Raymond in prison. When the question of bail came up, he was the only family member to be supportive of his father and offered to let his father come stay with him if he were to be released on bail. A number of the siblings went for counseling together in an attempt to work through the issues raised by the murder. (A service provider)

Families may be forced to make some hard decisions regarding their relationships after the murder. In the case above, Mrs. Raymond

faces multiple losses: (a) her daughter who was murdered, (b) perhaps a son who is siding with his father, (c) her husband who is in prison, and (d) the family as it existed before the murder. Each decision may leave co-victims with an increased feeling of loss and new mourning issues. They are often left to grieve not only the loved one who was murdered but also other family members who are now estranged, perhaps forever—as well as the loss of the family itself. Co-victims are commonly overwhelmed by intense feelings of anger that may be directed at different targets in rapid succession—the murderer, the victim, the other members of the family, and even themselves.

The question of whether to forgive the defendant also plays a prominent role in intrafamily homicides, possibly further dividing the family. Because of strong ties, some co-victims may be aware of extenuating circumstances and feel compassion for the murderer. This feeling of forgiveness may not be shared by family members who still feel only betrayed by and anger toward the defendant.

Because of the amount of denial often exhibited in intrafamily homicide, co-victims may not seek helping interventions; they may eschew the very notion of assistance such as counseling. Furthermore, even if the co-victim agrees to it, a homicide support group may not be an appropriate intervention, particularly if other family members attend the same group. Such groups rarely prove helpful and can lead to a potentially volatile situation. Under the right circumstances, however, counseling can be effective, especially if the sessions get beyond personal issues and assist the co-victim to work on healthier relationships. Experience shows that support groups with this same focus may be an even better choice than either homicide peer groups or one-on-one counseling.

The court setting can be an arena fraught with difficulties and perhaps violence as tempers flare and anger escalates among family members. Court administrators may often need to put extra officers on duty in an attempt to quell verbal and physical confrontations.

> Sherwood Gease, brother of the victim . . . had just testified and was passing the defense table when he directed an insulting gesture at his nephew [the defendant]. The defendant returned the gesture and followed with a stream of obscenities. Within seconds, the two lunged at each other but were quickly stopped by the three sheriff's deputies in the courtroom. As they wrestled onto a bench, Sherwood Gease picked up a chair to hurl at him. (Paik, 1995, p. B7)

In 1994 and 1995, two prominent intrafamily murder cases received worldwide attention: Susan Smith's murder of her children in Union, South Carolina, and the O. J. Simpson case in which Mr. Simpson was accused (and later acquitted) of murdering his former wife, Nicole, and Ronald Goldman, her friend. These cases are prime illustrations of the pain and anguish generated by an intrafamily murder.

PEDICIDE

Pedicide, the killing of children aged 1 through 16, and infanticide, the killing of children under the age of 1, is an increasing problem in the United States. At least half of all such cases are perpetrated by parents (Marzuk, Tardiff, & Hirsch, 1992, p. 100). As child abuse rates increase, the number of child homicides also increases.

Studies have implicated teen pregnancy, drugs, and poverty as among the primary causes contributing to the increase in child abuse. In a growing number of these cases, the perpetrator among the nonparent group is not a stranger but the stepfather, paramour, or live-in boyfriend. Researchers point to this presence in the home as one of the greatest risk factors. In addition, when the boyfriend is placed in a position of trust and responsibility as the baby-sitter, the child's vulnerability increases.

When a child is murdered by the boyfriend, the mother may react in surprising ways. Although the mother may exhibit shock, anger, and guilt, there may also be denial of the boyfriend's culpability. Many mothers, while grieving for their children, continue to have ambivalent feelings toward the boyfriend. Some mothers maintain their loyalty, even to the extent of refusing to testify against the boyfriend in court. Blame is often directed toward the mother as well as the perpetrator, especially if there was evidence of prior child abuse and the mother was aware of or witness to it and did not intervene.

> "He never told me," she said. "He never told me he hurt two other kids. If I would have known. . . . I trusted him." . . . Now, she trusts no one. "I mean, I've talked to guys, but that's it," she said. "I tell my girlfriends they have to be careful, because you never know." (Mother of child murdered by her boyfriend, quoted in Woodall, 1995, p. A17)

The circumstances of pedicide and infanticide have tragic consequences for everyone involved, including the community. Members of the criminal justice system, victim advocates, and other caregivers may feel incapable or frustrated in their attempts to offer any significant assistance to the mother. Grandparents, who are also the co-victims, find their pain and grief compounded by the confusion over their daughter's role and subsequent response to the murder. They may not be offered any support in managing their own grief nor be in a position to offer any assistance to their own daughter.

DOMESTIC VIOLENCE

The term *domestic violence* refers to persons related by blood or legal ties and to others having an intimate past or present relationship with the victim. This can include any number of combinations of relationships and encompasses parents and children as well.

> With her bruises captured in photographs and her fear echoing on a 911 audiotape even after her death, Nicole Brown Simpson has unleashed a wave of support for battered women and firmly anchored domestic violence in the American psyche as a problem that must be dealt with, experts say. (Jones, 1995, p. A28)

Domestic violence has always been part of the fabric of our society. The "dirty little secret," as it is often referred to, has contributed to recent high-profile cases in the criminal justice system. These cases, as well as new legislation, such as the 1994 Violence Against Women Act of the federal crime bill, have helped legitimize the issue. Beating one's spouse or partner is no longer considered a private matter and is now widely regarded as a criminal act.

Recent statistics document the extent to which domestic violence has touched U.S. society:

- An estimated 8 to 12 million American women are at risk of being abused by their current or former intimate partners (Flitcraft, Hadley, Hendricks-Matthews, McLeer, & Warshaw, 1992, p. 40).
- Each year, more than 1 million women seek medical treatment for injuries inflicted by husbands, ex-husbands, or boyfriends (National Clearinghouse for the Defense of Battered Women, 1995, p. 217). Battered women may account for 22% to 35% of women seeking care for any reason in emergency departments (Flitcraft et al., 1992, p. 40).
- The Bureau of Labor Statistics reports that an estimated 4 million women are battered each year by their partners (English, 1995, p. A20). Many in the field consider this number to be grossly underestimated because many cases of domestic abuse go unreported.
- Domestic violence occurs across all socioeconomic lines.

In the last 20 years, as a result of the women's movement, human and social services for domestic violence victims have greatly increased in both quality and quantity. Lawmakers—federal, state, and local—have been increasingly supportive in passing and funding legislation to benefit the victims. The criminal justice system has finally begun to make positive strides in its response to domestic violence, but there is still much to improve.

Domestic Violence and Murder

Domestic violence and murder are often strongly connected. The incidents of domestic violence put the victims at risk for increasing and potentially more lethal violence. There is no question that the family unit can be a violent place.

> An estimated 1,432 females were killed by intimates (husbands, ex-husbands, boyfriends, or ex-boyfriends) in 1992. Female victims represented 70% of the intimate murder victims. Out of *all* female murder victims, about 33% were killed by an intimate compared to only 4% of male murder victims. (Zawitz, Klaus, Bachman, Langan, Graziadei, & Harlow, 1994, p. 2)

Spousal and partner homicide is well documented in a number of excellent resources that look at both men and women as the perpetrators of domestic violence. In-depth information is easily accessible and focuses on demographics, causes, prevention, intervention, and

sociolegal responses, concentrating on the victims of domestic violence and how best to protect them, as well as how best to promote healing after the violence has occurred.

Few, if any, formal follow-up programs track the effects of the aftermath of domestic violence on the victims. This reflects the lack of systems for data collection that are reflective of family relationships, although plans are under way to make sweeping changes that should remedy this situation. There is also little to document the experience of, and the response to, the other set of victims of domestic abuse—the families and friends of those killed by homicide among intimates.

Issues Leading to Blame

There are certainly times when the man is a victim of battering and may even seek a restraining order. It is more common, however, for the victim to be a woman, and the degree of injury sustained during an incident is likely to be far worse for her. Experts in the field of domestic violence agree that a woman with a history of being battered by her partner will find her life most at risk when she seeks to end the relationship: an informal or formal separation, filing for a restraining or protection order, or filing for divorce.

The issue of restraining orders offers some troublesome concerns. A restraining order is only a piece of paper. Although it has the enforcement power of the court behind it, it cannot stop bullets. A family member may be thwarted by an unwieldy criminal justice system in assisting a domestic violence victim to obtain a restraining order. In the meantime, someone may be killed by a partner. Or, after a woman has been granted a restraining order, she may ultimately be killed by her partner. In either case, co-victims may feel angry, resentful, and frustrated, blaming the criminal justice system and domestic violence agencies.

In response to their anger, co-victims have sued agencies that they felt were negligent in providing protection for a loved one who had been a victim of domestic violence. One of the substantive provisions under the Violence Against Women Act of 1994 provides the first federal civil rights remedy for gender-based violent crimes. The law

allows victims of such crimes, as well as their estates, to bring civil actions in federal court for damages and other relief.

> Last Saturday in Yuba City, California, a man was arrested for stabbing his estranged wife and reportedly telling her, "O. J. got away with it, and so will I." (Jones, 1995, p. A28)

Domestic violence occurs between two people who have a prior relationship. This is not a crime between strangers. If it were, the law would be considerably less lenient in its approach toward response and intervention. In most cases, co-victims also have some previous knowledge of, or even relationship with, the perpetrator. These issues can greatly add to co-victims' grief and loss. They may feel that they have to choose sides in the aftermath of murder. This can be especially difficult if the victim leaves surviving children who are also the perpetrator's children.

The dual issues of anger and forgiveness, which are a possibility for all co-victims of homicide, are intensified in many domestic violence cases. As is often the case, a battered woman may obtain a protection order and then return to the relationship. This can happen numerous times. The reasons are myriad and have been examined in other literature. If the woman is ultimately murdered by her spouse or partner, the co-victims may experience a great deal of anger and frustration with her because she is no longer available to respond to their doubts and questions. These emotions are often shared and articulated by the criminal justice system, the media, and family and friends. Blaming the victim, not an uncommon attribute, is certainly present in many domestic violence murders. Lack of understanding of the escalating process of domestic violence is usually the source of the blame. Co-victims may find that they cannot adequately mourn before they forgive the victim, but without a fuller comprehension of the victim's plight, this may be difficult to achieve.

Battered Woman Syndrome

Battered women may also kill their batterers; men represent 30% of the intimate murder victims (Zawitz et al., 1994, p. 2). In recent

years, the increased credibility of the battered woman syndrome has enabled it to be used as a homicide defense. This plea maintains that a woman has killed her abuser in self-defense and, at the time of the killing, had been a victim of abuse. In a recent study of such cases, 9% to 12% of the women had their cases diverted, rejected, or dismissed before trial because of evidence of past abuse (National Clearinghouse for the Defense of Battered Women, 1995, p. 1). The claim of self-defense is the most frequent reason for the acquittal of a woman, but it is not an irrefutable defense. Women who were previously convicted and incarcerated prior to the understanding of the battered woman syndrome, however, are now in the position of being pardoned or having their sentences commuted after evidence is presented that attests to their having been abused.

On the other hand, the use of this defense is frequently contested by a co-victim who tends to deny or disregard the history of abuse and still seeks justice in the form of a conviction and incarceration of the perpetrator. Many victims' families are more accepting of the woman's claim, however, and agree not to prosecute. These complex factors of domestic violence can be quite distressing and override familial connections. Co-victims are often faced with confusing emotions and lack the normal support of family and friends who may now be their adversaries.

Considerations for Caregivers

Caregivers have many factors to consider when planning assistance to a co-victim of a domestic violence murder. Not only is the relationship of the co-victim to the victim important, but the caregiver should determine whether the co-victim was privy to any knowledge of previous domestic violence. The co-victim may experience guilt or anger at not recognizing the signs or having ignored or denied the existence of violence. The use of post-incident analysis can help the co-victim to better understand what has happened; tackle the question "Why?"; dissipate some of the anger, guilt, and frustration; and restore a level of control.

The purpose of a post-incident analysis is not to obsess over what has happened or fix blame. Co-victims often initiate a post-incident analysis by asking what they can do so "no other family has to go

through this pain." Ideally, participants should include members of the criminal justice system, both police and prosecutors, advocates from domestic abuse and homicide victim witness units, and family members who want to attend. If various factions of the family are antagonistic, it may be inappropriate to have them at the same table. All who attend the session must be willing to abide by preestablished ground rules so that the process can be healing and informative. The criminal justice system and advocates, for example, may be able to apply any new understanding toward making positive changes in policy regarding issues such as protection orders and new legislation.

Victim advocates and other caregivers may encounter difficulties in providing assistance to co-victims in domestic abuse cases. First of all, caregivers may themselves have unresolved issues concerning domestic violence—conscious or unconscious—that interfere with their ability to help clients. Second, caregivers may not always be knowledgeable about domestic abuse. For example, advocates and other caregivers are also capable of blaming the victim. The role of agencies is to provide services for the co-victim. They may find themselves in a dilemma, however, when their sympathy is directed toward an abused woman who is also the defendant. Thus, many issues can severely hamper the proficiency of caregivers who pride themselves as professionals.

Caregivers should learn as much as possible about domestic violence and understand their own feelings. If they cannot manage their beliefs in such a way as to provide services that benefit the co-victim, they may need to refer the case, when possible, to another advocate. In any event, they will need a great deal of sensitivity in their interactions with co-victims of intrafamily homicide.

By Marcia Sheinberg and Peter Fraenkel

Loyalty Violated

Ambivalence haunts the victims of sexual abuse

WHEN THE SEXUAL ABUSE of a child by a family member comes to light, painful loyalty binds surface for everyone involved. The abused child may feel terribly guilty for having gotten an adult in trouble, especially if the offender previously preyed on this very vulnerability to manipulate her into secrecy. The child may secretly blame the nonoffending parent—usually the mother—for not preventing the abuse, even fearing that the mother knew about the abuse and did not stop it. The child also may fear that the mother's loyalty to the offender will pave the way for his return, making the child again vulnerable to abuse.

In our approach, we try to widen the focus to address the conflicting family loyalties and emotions that incest sets in motion. Our goal is to engage family members to collaborate with us to direct the flow and content of the sessions—determining how much to talk about the abuse, when and with whom.

ILLUSTRATION BY SALLY WERN COMPORT

RUTH, A 29-YEAR-OLD IRISH AMERICAN, CATHOLIC woman from Queens, New York, first came to see us after her family had been torn apart by incest. (Marcia Sheinberg was the therapist, and the treatment team behind the one-way mirror was Peter Fraenkel, Fiona True and Sippio Small.) Three months earlier, she had been happily living with her second husband, Tom, a city fireman, their three young children and Ruth's 11-year-old daughter, Laurie, from a previous marriage. Now Tom was in a cell on Riker's Island awaiting trial for having sexually abused his stepdaughter. Ruth had been charged with child neglect for not having reported the abuse and a Family Court judge had sent all four children to live with Ruth's parents, who lived a few doors away. A child advocacy center had referred the family to us.

We usually see the nonoffending parent first, allowing the mother an opportunity to present her account and express her feelings about the offender, her daughter and herself without having to edit what she says because the child is present. Ruth told us that two months earlier, she had found Tom at her daughter's bedroom door in the middle of the night and Laurie crying in the bathroom. Ruth had been abused by her own brother as a child; she took one look at Laurie's tear-stained face and knew what Tom had done. "When I got out of the bathroom with her, I opened the door to kick him out," she told us. But Tom had pushed her against the wall and told her that if she called the police, they would believe him, not her, since he worked for the city. "Shocked and stunned and mortified," Ruth was intimidated into silence.

Like most women in her position, Ruth could take no action that would not affect the lives of all the people she loved—people who now had radically divergent and competing needs. She wanted somehow to protect her daughter without reporting Tom. She didn't want to cause additional stress to her parents, especially because her father was battling cancer. She worried about how her younger children would react to the loss of their father, to whom they were very attached. She worried about how the family would survive without Tom, the only breadwinner. She was also ►

frightened that her husband might become violent if she reported him.

Waiting for a moment that felt safe to call the police, Ruth sent Laurie to stay with her grandparents when Tom was at home. Ten days later, Laurie told a friend, and the friend's mother called the police. Tom was arrested. At the hearing, Ruth told us, she discovered to her horror that Tom had been having oral sex with Laurie and sodomizing her as often as three times a week for more than a year.

Our immediate reaction to hearing an account of abuse is to support the mother in her anger, rage and sense of betrayal. Yet, we believe that it is critical to also give her a chance to talk about her positive feelings for the perpetrator. We find that the more we elicit conversation about the woman's attachment, normalize it and help her hold its inherent contradictions, the more she will feel clarity instead of confusion, and strength instead of shame. Our acceptance of the mother's complex feelings toward the abuser also seems to help her be more understanding and compassionate about her child's complex feelings for her, which makes it much safer for the child to share those feelings rather than act them out. Marcia asked Ruth if she missed her husband. Ruth thought for a minute, and then said, "I know I'm supposed to hate this person who abused my daughter, but I can't help loving him."

Marcia invited Laurie to the next session with her mother. We always begin the first session with the child and mother both present, so that the mother can give the child permission to speak with us. This minimizes the loyalty conflict that therapy might otherwise create, and honors the mother's relationship with her daughter. Although Marcia made it clear that eventually they would probably want to talk about the abuse, she gave Ruth and Laurie the choice about where to start, trying to help repair Laurie's damaged sense of agency and control. If Laurie had begun to talk about the abuse, we would have followed her lead. Instead, she wanted to talk about the ongoing conflicts she and Ruth were having. Ruth described her daughter's "bad temper" and "big ►

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mouth," which had worsened since the children went to live with their grandparents. Laurie didn't disagree. "I don't know why," she said, "but this bitchiness just slips out." Marcia asked Ruth, "Are you a 'big mouth' like your daughter, or are you different?" Ruth thought about it and said, "I let people hurt me and hurt me, and I let it build up. Then I blow up and I'll yell, and then I won't take it anymore." Laurie was listening intently. Marcia asked, "Laurie doesn't let it build up?" Ruth replied, "No. Laurie will tell you where it's at. I like that quality in her because I don't think that Laurie will ever take what I take."

The mood in the room shifted almost palpably as mother and daughter connected. Ruth began to see her daughter's outspokenness not as a negative quality, but as a way of protecting herself. The theme of self-protection provided the bridge for mother and daughter to begin talking about their wrenching experiences since the disclosure. At this point, Marcia explained that we encourage both kids and their parents to choose how much to talk about the abuse and whether to do so first in an individual session with the therapist or with the mother present. She also explained that at the end of the individual session, Laurie could decide what information and feelings she wanted to talk about in the session with her mother. Mother and daughter seemed pleased with these ground rules.

Laurie chose to talk about the abuse first with Marcia alone. As therapist and client settled into their first individual session, Laurie spoke about how hard it was to be separated from her mother. Marcia asked her, "Do you miss Tom?" Laurie answered with some relief, "I do miss him a little, 'cause he was there when I got glass in my hand and when I had to go to the hospital 'cause I was rollerblading. He took me to get ice cream, he bought me stuff and he was really nice." Irrespective of her answer, asking Laurie the question about missing Tom sent Laurie the message that she did not have to conceal her complex feelings in order to remain attached to protective, caring adults. ►

Instead of "imposing" therapy on Laurie, Marcia explained to the child our belief that the more she talked about her abuse, the less troubling her feelings would be. She also explained, "We think when it stays as a secret between you and Tom, you may feel that only he knows some things about you, and this may keep you from feeling completely good about yourself." Marcia also made it clear that Laurie could decide how much to tell us, when and at what pace. Laurie hesitantly described how she'd wrap herself in quilts and close her eyes. "I made believe that he couldn't touch me because I was wrapped around with so many blankets," she said. "But he would just touch me and then, like, when he was done he would just leave, and it seemed, like, all better the next morning. He would never talk about it." She told us she felt she was to blame—for wearing T-shirts that might have "given him ideas," and simply for being "a little bit pretty." "Sometimes I prayed, like, let me be ugly tonight, let me just be ugly just for tonight, and then tomorrow I'll be so pretty. And it would never happen," she said. "He told me not to tell my mother 'cause I would be taken away from her and I would never see her ever again. And he threatened me that if I told my mother, when he comes out of jail he would kill me."

At this point, Marcia expanded the conversation to include Laurie's perception of her mother's feelings about Tom. She asked Laurie whether she thought her mother missed Tom, and Laurie said, "She still has little parts of her that love him." When Marcia asked her what she would want her mother to say that would make her feel better, Laurie immediately said, "That she wouldn't go back with him. But she'll probably say that he won't come back, that she'll keep me safe." Her ambivalence about whether she could trust her mother led into a discussion about Laurie's nagging questions about whether her mother had known she was being abused. If her mother had failed to protect her before, she might fail again. "Sometimes I'd just say, 'Ma!'" Laurie said. "And she'd say 'What?' And I ►

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wanted to tell her, but I was, like, 'Never mind.'"

"So does a part of you feel like she should have figured it out?"

"Yeah," said Laurie.

One of the problems of meeting individually with the child is that important information can become a secret between therapist and child, leaving out the nonoffending parent again. So at the end of this session, Marcia asked Laurie what she wanted to share with her mother and how she wanted to share it. We call this planning discussion with the child the "Decision Dialogue," and it is one of the most important aspects of our approach. It empowers the child and builds her sense of control, and tells us where the remaining rifts in her relationships with protective adults may be.

Laurie asked Marcia to take the lead with her mother, as she was a bit anxious about how her mother might react. Marcia started the session with mother and daughter by explaining to Ruth that Laurie knows Ruth still loves Tom and is afraid that she might go back to him, even though she doesn't think Ruth will. Ruth paused and then said, firmly and quietly, looking into her daughter's eyes, "Let me just tell you, I will never get back together with Tom, because of what he did to you and to us. He destroyed any type of trust that anybody could ever have. So you don't ever have to be worried that I would ever even consider taking him back, okay?"

Softly, Laurie said, "Thank you," and tears poured down her face. After several moving interchanges, in which mother and daughter discussed their feelings about the abuse openly for the first time, Ruth took Laurie in her arms, holding her and stroking her hair as her daughter cried. "He can never, ever, ever, ever, ever, ever, ever hurt you again, okay?" Ruth said. In later sessions, we built on this positive experience to encourage Laurie to bring up other concerns, including her anger that her mother did not report the abuse immediately and the fear that her mother secretly blamed her for disclosing the abuse to a friend.

Like other abused children we work with, Laurie needed to hear over and

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over again, from both parents, that the abuse was not her fault, regardless of the circumstances. We helped mother and daughter talk through and clarify that Laurie was not to blame, and we arranged for Tom to write Laurie a letter from prison, taking full responsibility for what had occurred.

At the same time, we did not abandon Ruth to her complex feelings about Tom. "You know, I loved him so much," Ruth told us in a session alone, not long after Tom was sentenced to six years in prison, with little possibility of therapy. "He was my best friend. It's hard not being able to talk to him about how I'm feeling. And then I say to myself, 'Look what he did to Laurie, look what he did to us.' And then there is a little part of me that says, 'Yes, he did do that, and yes, he's being punished, but you can still love him.'"

"And miss him," Marcia said. "You miss him." As Ruth spoke about her bewilderment—why had Tom done it?—Marcia said, "Well, you're in a tough spot. I think it's hard for you to accept this ending in which he's out of your life for good without even understanding why he did what he did. There is no closure."

"Exactly." said Ruth. "Yet, I don't think I could ever trust him again."

As she spoke, Ruth made a distinction between her needs as a woman and her responsibilities as a parent, and in subsequent sessions she made a further distinction between wanting a partner and wanting Tom. By expressing the full and complex range of her emotions, she felt more empowered. While she struggled financially, she also began to date, and shared with us how she quickly extricated herself from situations that were not in her best interest.

We continued to work with the family for several months more, helping mother and daughter talk about Ruth's parenting style and meeting with the younger children and extended family members. By the end of therapy, much had improved. Laurie told us that she rarely experienced intrusive thoughts, sexual preoccupations, difficulty in talking with her mother about the abuse or feelings of responsibility for what had occurred. Although Ruth knew she would still have to deal with her feelings for Tom and with his relationship to their children, she continued to feel confident that she could protect her children and make good decisions as a woman and a mother. When the family decided to end therapy, Ruth's relationship with Laurie was loving and supportive.

Loyalty issues in families in which there has been incest are often cast as either/or choices for family members, as well as for the therapists treating them. By bringing forth complex and, at times, contradictory feelings of attachment, therapists help family members change how they relate and yet maintain connection with one another. Ruth learned that she could continue to love her husband and not betray her daughter's trust, or jeopardize her safety. Laurie learned that she could articulate anger to her mother without being disloyal.

CASE COMMENTARY

By Mary Jo Barrett

Marcia Sheinberg and Peter Fraenkel offer a wonderful example of the benefit of helping a family explore the entire range of feelings intrafamilial sexual abuse triggers. I was quite thrilled to see them following a blueprint that allowed for both individual and family sessions, and to see how they encouraged the mother-daughter dyad to be collaborators in the treatment process. I was also pleased to see that even though they were not engaging the father in treatment, the therapists encouraged the mother to express all her feelings—even positive ones—about him. Sheinberg and her team seem to work out of the same assumption I do: incest is never a simple story of perpetrator as sick, hurtful monster. It's a complex story reflecting social and political as well as family and intrapsychic variables.

Any effective sex abuse treatment that looks at loyalty issues must take into account not only the family dynamics, but also loyalties to race, gender, class and culture. Sheinberg asked questions about love—"Do you miss Tom?"—but I wondered if she also asked, "What is it like for you, as a woman, not to have a man in your ►

life now?" "As a Catholic, what does this mean to you?" "As an Irish American, what does this mean to you?" It is crucial that therapists look at the whole context in which incest occurs, beyond the loyalties of love in dyadic treatment. That is why an array of individual, family and group work is necessary in sex abuse cases, because each forum offers different opportunities to broaden the therapeutic context.

I also appreciated the authors' use of the term "Decision Dialogue." In our follow-up interviews with families who have completed our treatment program, the majority said it was helpful to experience treatment as a program with well-defined stages in the healing process. It appears that in their attempt to collaborate with clients, Sheinberg and her team share with them the stages of treatment, overtly letting them know what the treatment process is all about. This is probably useful for all our clients, but especially for clients dealing with incest. Where there is incest, there are secrets—people doing things while other people don't understand what is happening or why—and therapy should not replicate that secrecy and misinformation. One of our clients once told me, "Therapy was the first time I knew what was happening and why it was happening."

My biggest concern with this case wasn't really about the case, but about what I imagine therapists who read it might think when they compare it to their own work. This was a case with a happy ending: the mother and daughter were able to come together and strengthen their bond, while the mother made a clear, credible commitment to her daughter's safety. There is nothing wrong with a case that presents a success—we can learn a lot from it—but I feel compelled to offer a reality check. As Sheinberg and her team surely have found, not every—maybe not most—cases involving incest resolve so neatly. While Sheinberg and Fraenkel may offer a solid example of good work, they do not have a recipe that will guarantee success. Even if therapists broaden their clinical focus and explore conflicting family loyalties, there are dozens of other obstacles to a happy ending. For example, there is

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the complicated fact that violence in families is connected to family members' reactions to their experiences within an oppressive social and political system. There are wider systems that impact on the family—judicial, educational, child welfare. In some families, incestuous perpetrators are still in the home or have continued access to the child. And the clients, themselves, can be much more difficult—mothers who are more confused or entrenched in their confusing loyalties than this mother; children who are more ambivalent, more angry (or less angry) than this child. I would hate for readers to believe they were doing something wrong because they are not experiencing such satisfying results in their own work.

AUTHORS' RESPONSE

We appreciate Mary Jo Barrett's thoughtful response and her caveat to look beyond family dynamics to the social-political systems in which incest is embedded. We ourselves have extended our work outside the consulting room and, several years ago, initiated a consortium of New York City agencies that actively transformed the way the investigative, case management and treatment process is carried out. Currently, we work collaboratively with a large child advocacy center, training workers in the agencies that the advocacy center refers to, so that there is a community of care and a common approach to working with abused children and their families. Work at the level of larger systems greatly reduces the complications that Barrett notes interfere with positive treatment outcomes for families.

Barrett raises the question of whether we address race, culture and ethnicity in treatment. We share her commitment to bringing forth these issues. Our approach is to ask questions that elicit each family member's unique sense of identity, inviting exploration of issues of gender, race, class and culture. We are interested not only in how these aspects of identity affect their experience of abuse, but also how these may serve as resources for the family's healing. ■

Marcia Sheinberg, M.S.W., is director of Clinical Training and Clinical Services for the Ackerman Institute for the Family and founder and director of the Sex Abuse Project, Making Families Safe for Children. Peter Fraenkel, Ph.D., is teaching faculty and director of research at the Ackerman Institute, a clinical member of the Sex Abuse Project and associate professor of psychology at The City University of New York. This case is adapted from their forthcoming book from Guilford Press, The Dilemmas of Incest: A Relational, Family-Centered Approach. *Address: Ackerman Institute for the Family, 149 East 78th Street, New York, NY 10021.*

Mary Jo Barrett, M.S.W., is the director of the Center for Contextual Change in Skokie, Illinois, specializing in the treatment of violence and its aftermath. She is the coauthor of Treating Incest and The Systemic Treatment of Incest. Address: Center for Contextual Change, 9239 Gros Point, Skokie, IL 60077

Section C:
Victim Bill of Rights: Its Past and Future

Section C: Victim Bill of Rights: Its Past and Future

Panelists:

Andrea Cabral
Chief of District Courts and Community Prosecutions
Suffolk County District Attorney's Office
One Bulfinch Place
Boston, MA 02114
(617) 619-4000

Janet E. Fine
Chief, Victim Witness Assistance Program
Suffolk County District Attorney's Office
One Bulfinch Place
Boston, MA 02114
(617) 619-4000

Marcia M. Hill
Director, Victims Service Unit
Massachusetts Parole Board
27-43 Wormwood Street, Suite 300
Boston, MA 02210
(617) 727-3271

Dave Johnson
Father of a child sexual assault survivor
c/o MOVA
1 Ashburton Place, Suite 1101
Boston, MA 02108
(617) 727-5200

Coordinator: **Rhonda Matthews**

THE VICTIM BILL OF RIGHTS

Massachusetts General Laws, Chapter 258B (excerpted)

§ 1. Definitions.
The following words as used in this chapter shall have the following meanings, unless the context otherwise requires:

"Board", the victim and witness assistance board as established in section four;

"Court", a forum established under the general laws for the adjudication of criminal and delinquency complaints or indictments;

"Crime", an act committed in the commonwealth which would constitute a crime if committed by a competent adult including any act which may result in an adjudication of delinquency;

"Disposition", the sentencing or determination of penalty or punishment to be imposed upon a person convicted of a crime or found delinquent or against whom a finding of sufficient facts for conviction or finding of delinquency is made;

"Family member", a spouse, child, stepchild, sibling, parent, step-parent, dependent, as defined in section one of chapter two hundred and fifty-eight C, or legal guardian of a victim, unless such family member has been charged in relation to the crime against the victim;

"Prosecutor", the attorney general, assistant attorneys general, district attorney, assistant district attorneys, police prosecutors, other attorneys specially appointed to aid in the prosecution of a case, law students approved for practice pursuant to and acting as authorized by the rules of the supreme judicial court, or any other person acting on behalf of the commonwealth, including victim-witness advocates;

"Restitution", money or services which a court orders a defendant to pay or render to a victim as part of the disposition;

"Victim", any natural person who suffers direct or threatened physical, emotional, or financial harm as the result of the commission or attempted commission of a crime or delinquency offense, as demonstrated by the issuance of a complaint or indictment, the family members of such person if the person is a minor, incompetent or deceased, and, for relevant provisions of this chapter, a person who is the subject of a case reported to a prosecutor pursuant to section eighteen of chapter nineteen A, sections five and nine of chapter nineteen C, and section fifty-one B of chapter one hundred nineteen, and the family members of such person if the person is a minor, incompetent or deceased;

"Victim-witness advocate", an individual employed by a prosecutor, the board, or other criminal justice agency to provide necessary and essential services in carrying out policies and procedures under this chapter.

"Witness", any person who has been or is expected to be summoned to testify for the prosecution whether or not any action or proceeding has yet been commenced.

§ 2. Services Not Limited to Victims of Crimes that are prosecuted.

Prosecutors shall not be precluded from providing, subject to appropriation, services under this chapter to any natural person or family member of such natural person who suffers direct or threatened physical, emotional or financial harm as the result of the commission or attempted commission of a crime or delinquency offense in which complaints or indictments have not been issued.

§ 3. Rights of Victims and Witnesses of Crime.

To provide victims a meaningful role in the criminal justice system, victims and witnesses of crime, or in the event the victim is deceased, the family members of the victim, shall be afforded the following basic and fundamental rights, to the greatest extent possible and subject to appropriation and to available resources, with priority for services to be provided to victims of crimes against the person and crimes where physical injury to a person results:

(a) for victims, to be informed by the prosecutor about the victim's rights in the criminal process, including but not limited to the rights provided under this chapter. At the beginning of the criminal justice process, the prosecutor shall provide an explanation to the victim of how a case progresses through the criminal justice system, what the victim's role is in the process, what the system may expect from the victim, why the system requires this, and, if the victim requests, the prosecutor shall periodically apprise the victim of significant developments in the case;

(b) for victims and family members, to be present at all court proceedings related to the offense committed against the victim, unless the victim or family member is to testify and the court determines that the person's testimony would be materially affected by hearing other testimony at trial and orders the person to be excluded from the courtroom during certain other testimony;

(c) for victims and witnesses, to be notified by the prosecutor, in a timely manner, when a court proceeding to which they have been summoned will not go on as scheduled, provided that such changes are known in advance. In order to notify victims and witnesses, a form shall be provided to them by the prosecutor for the purpose of maintaining a current telephone number and address. The victim or witness shall thereafter maintain with the prosecutor a current telephone number and address;

(d) for victims and witnesses, to be provided with information by the prosecutor as to the level of protection available and to receive protection from the local law enforcement agencies from harm and threats of harm arising out of their cooperation with law enforcement and prosecution efforts;

(e) for victims, to be informed by the prosecutor of financial assistance and other social services available to victims, including information relative to applying for such assistance or services;

(f) for victims and witnesses, to a prompt disposition of the case in which they are involved as a victim or a witness;

(g) for victims, to confer with the prosecutor before the commencement of the trial, before any hearing on motions by the defense to obtain psychiatric or other confidential records, and before the filing of a nolle prosequi or other act by the commonwealth terminating the prosecution or before the submission of the commonwealth's proposed sentence recommendation to the court. The prosecutor shall inform the court of the victim's position, if known, regarding the prosecutor's sentence recommendation. The right of the victim to confer with the prosecutor does not include the authority to direct the prosecution of the case;

(h) for victims and witnesses, to be informed of the right to request confidentiality in the criminal justice system. Upon the court's approval of such request, no law enforcement agency, prosecutor, defense counsel, or parole, probation or corrections official may disclose or state in open court, except among themselves, the residential address, telephone number, or place of employment or school of the victim, a victim's family member, or a witness, except as otherwise ordered by the court. The court may enter such other orders or conditions to maintain limited disclosure of the information as it deems appropriate to protect the privacy and safety of victims, victims' family members and witnesses;

(i) for victims, family members and witnesses, to be provided, subject to appropriation and to available resources, by the prosecutor with a secure waiting area or room which is separate from the waiting area of the defendant or the defendant's family, friends, attorneys or witnesses, during court proceedings. The court shall, subject to appropriation and to available resources, designate a waiting area at each courthouse and develop any reasonable safeguards to minimize contact between victims and the defendant, or the defendant's family, friends, attorneys or witnesses;

(j) for victims and witnesses, to be informed by the court and the prosecutor of procedures to be followed in order to apply for and receive any witness fee to which they are entitled;

(k) for victims and witnesses, to be provided, where appropriate, with employer and creditor intercession services by the prosecutor to seek employer cooperation in minimizing employees' loss of pay and other benefits resulting from their participation in the criminal justice process, and to seek consideration from creditors if the victim is unable, temporarily, to continue payments;

(l) for victims or witnesses who have received a subpoena to testify, to be free from discharge or penalty or threat of discharge or penalty by his employer by reason of his attendance as a witness at a criminal proceeding. A victim or witness who notifies his employer of his subpoena to appear as a witness prior to his attendance, shall not on account of his absence from employment by reason of such witness service be subject to discharge or penalty by his employer. Any employer or agent of said employer who discharges or disciplines or continues to threaten to discharge or discipline a victim or witness because that victim or witness is subpoenaed to attend court for the purpose of giving testimony may be subject to the sanctions stated in section fourteen A of chapter two hundred and sixty-eight;

(m) for victims and witnesses, to be informed of the right to submit to or decline an interview by defense counsel or anyone acting on the defendant's behalf, except when responding to lawful process, and, if the victim or witness decides to submit to an interview, the right to impose reasonable conditions on the conduct of the interview;

(n) for victims, to confer with the probation officer prior to the filing of the full presentence report. If the victim is not available or declines to confer, the probation officer shall record that information in the report. If the probation officer is not able to confer with the victim or the victim declines to confer, the probation officer shall note in the full presentence report the reason why the probation officer did not make contact with the victim;

(o) for victims, to request that restitution be an element of the final disposition of a case and to obtain assistance from the prosecutor in the documentation of the victim's losses. If restitution is ordered as part of a case disposition, the victim has the right to receive from the probation department a copy of the schedule of restitution payments and the name and telephone number of the probation officer or other official who is responsible for supervising the defendant's payments. If the offender seeks to modify the restitution order, the offender's supervising probation officer shall provide notice to the victim and the victim shall have the right to be heard at any hearing relative to the proposed modification.

(p) for victims, to be heard through an oral and written victim impact statement at sentencing or the disposition of the case against the defendant about the effects of the crime on the victim and as to a recommended sentence, pursuant to section four B of chapter two hundred and seventy-nine, and to be heard at any other time deemed appropriate by the court. The victim also has a right to submit the victim impact statement to the parole board for inclusion in its records regarding the perpetrator of the crime;

(q) for victims, to be informed by the prosecutor of the final disposition of the case, including, where applicable, an explanation of the type of sentence imposed by the court and a copy of the court order setting forth the conditions of probation or other supervised or unsupervised release within

thirty days of establishing the conditions, with the name and telephone number of the probation officer, if any, assigned to the defendant;

(r) for victims, to have any personal property that was stolen or taken for evidentiary purposes, except contraband, property subject to evidentiary analysis, and property the ownership of which is disputed, returned by the court, the prosecutor or law enforcement agencies within ten days of its taking or recovery if it is not needed for law enforcement or prosecution purposes or as expeditiously as possible when said property is no longer needed for law enforcement or prosecution purposes;

(s) for victims, to be informed by the parole board of information regarding the defendant's parole eligibility and status in the criminal justice system;

(t) for victims, to be informed in advance by the appropriate custodial authority whenever the defendant receives a temporary, provisional or final release from custody, whenever a defendant is moved from a secure facility to a less-secure facility, and whenever the defendant escapes from custody. The victim shall be informed by the prosecutor about notification rights and the certification process required to access the criminal offender record information files. Persons requesting such notice must provide the appropriate authority with current information as to their address and telephone number;

(u) for victims, to be informed that the victim may have a right to pursue a civil action for damages relating to the crime, regardless of whether the court has ordered the defendant to make restitution to the victim.

(v) for one family member of a victim of a homicide, which the matter before the court is related, to possess in the courtroom a photograph, that is not of itself of an inflammatory nature, of the deceased victim that is not larger than eight by ten inches; provided, however, that at no time may the photograph be exposed or in any way displayed in the presence of any member of the jury, or the jury pool from which a jury is to be selected in a particular matter; provided, further, that nothing in this section shall preclude the admission into evidence of a photograph that the court deems relevant and material.

§ 4. Victim and Witness Assistance Board; Powers and Duties.

There is hereby established a victim and witness assistance board, to consist of five members who shall serve without compensation. Notwithstanding any provision of section six of chapter two hundred and sixty-eight A to the contrary, the board shall consist of the attorney general or his designee who shall be chairman, two district attorneys who shall be appointed by the governor, and two members of the public who shall be appointed by the governor, of whom one shall be a victim. The members of the board first appointed shall serve as follows: of the district attorneys appointed by the governor, one shall serve for three years and one shall serve for one year, of the members of

the public appointed by the governor, one shall serve for three years and one shall serve for two years. The successor of each such member shall serve for a term of three years and until his successor is duly appointed and qualified, except that any person appointed to fill a vacancy shall serve only for the unexpired term. Any member of the board shall be eligible for reappointment.

The board shall by majority vote of its members, appoint an executive director who shall serve, subject to appropriation, at such rate of compensation as the board directs for a term of three years unless removed for cause by a vote of four members of the board. The executive director, subject to appropriation, shall have the power to hire such staff, subject to the approval of the board, as is needed to fulfill the powers and duties of the board. The executive director shall have such other powers and duties as the board may delegate to him.

The provisions of chapter thirty-one shall not apply to the executive director or any employee of the board.

The board shall review and approve program plans, annual reports, and the implementation and operation of programs as described in this chapter. The board shall promulgate rules for the preparation and review of such programs and annual reports.

In addition to the foregoing, the board shall:

(a) have printed and shall make available to social service agencies, medical facilities, and law enforcement agencies, cards, posters, brochures or other materials explaining the victim and witness rights and services established under this chapter;

(b) assist hospitals, clinics and other medical facilities, whether public or private, in disseminating information giving notice of the rights established under this chapter. This assistance may include providing informational materials including posters suitable to be displayed in emergency and waiting rooms;

(c) assist law enforcement agencies in familiarizing all of their officers and employees with the crime victims' rights as provided under this chapter. This assistance may include supplying informational literature on this subject to be utilized as part of the training curriculum for all trainee officers; and

(d) assist all local law enforcement agencies in establishing procedures whereby expedient notification is given to victims and witnesses, as defined under this chapter, of the rights provided under this chapter. In municipalities which do not have a local law enforcement agency, the board shall establish procedures whereby it, in cooperation with the state police, shall give notice to victims of crimes as provided in this section.

§ 5. Programs to be created by District Attorneys.

Each district attorney shall create and maintain, to the extent reasonably possible and subject to the available resources, a program to afford victims and witnesses of crimes the rights and services described in this chapter. Those services shall include but not be limited to the following:

(a) court appearance notification services, including cancellations of appearances;
(b) informational services relative to the availability and collection of witness fees, victim compensation and restitution;
(c) escort and other transportation services related to the investigation or prosecution of the case, if necessary;
(d) case process notification services;
(e) employer intercession services;
(f) expedited return of property services;
(g) protection services;
(h) family support services including child and other dependent care services;
(i) waiting facilities; and
(j) social service referrals.

If you are a crime victim, you have certain rights under Massachusetts Law, and you are eligible for certain services.

For further information about victim rights and victim services, contact the victim witness program in your local District Attorney's office or one of the statewide agencies listed below.

DISTRICT ATTORNEY VICTIM WITNESS PROGRAMS

Berkshire County	(413) 443-3500
Bristol County	(508) 997-0711
Cape and Islands	(508) 362-8103
Essex County	(978) 745-6610
Hampden County	(413) 747-1038
Middlesex County	(617) 494-4604
Norfolk County	(781) 329-5440
Northwestern District - Franklin and Hampshire Counties	(413) 586-5780
Plymouth County	(508) 584-8120
Suffolk County	(617) 619-4000
Worcester County	(508) 792-0214

STATEWIDE VICTIM ASSISTANCE PROGRAMS

Office of the Attorney General	(617) 727-2200
Massachusetts Office for Victim Assistance	(617) 727-5200
Massachusetts Parole Board	(617) 727-3271
Criminal History Systems Board	(617) 660-4690

♻ This document is available in alternate formats.

VICTIM COMPENSATION

The Commonwealth of Massachusetts

TOM REILLY ATTORNEY GENERAL

Victim Compensation and Assistance Division

One Ashburton Place, 19th floor
Boston, MA 02108-1698
(617) 727-2200
TTY: (617) 727-4765
FAX: (617) 367-3906

Dear Friend,

Violent crime has a devastating impact on victims and their families. All too often, physical pain and psychological trauma are accompanied by mounting medical bills, lost wages and other expenses. No one should suffer a financial setback because of violent crime.

As Attorney General, I am deeply committed to expanding services for crime victims. My Victim Compensation Program uses funds obtained from criminal offenders to provide financial assistance, up to $25,000 per crime, to help victims pay for uninsured medical, dental, and counseling expenses, funeral and burial costs, and lost income. My dedicated staff can also assist you in understanding your rights as a crime victim, and in ensuring that you get *all* the services and assistance you need.

While no amount of money can compensate for a violent crime, Victim Compensation can provide crucial financial help. If you or a loved one has been victimized by a violent crime, please read this brochure to see if we can help you.

Sincerely,

Tom Reilly

Tom Reilly

WHO IS ELIGIBLE?

- Victims of violent crime occurring in Massachusetts
- Dependents and family members of homicide victims
- Any person responsible for the funeral expenses of a homicide victim

WHAT ARE THE REQUIREMENTS?

- The crime must have been reported to police within five days unless there is good cause for delay.
- You must cooperate with law enforcement officials in the investigation and prosecution of the crime unless there is a reasonable excuse not to cooperate.
- You must apply for compensation within three years of the crime. Victims under the age of 18 at the time of the crime may apply until age 21, or later in certain limited circumstances.
- Your out-of-pocket expenses must exceed $100, unless you are over age 60 or a victim of rape.

WHAT EXPENSES ARE COVERED?

To the extent insurance or other funds do not cover your expenses, you may be reimbursed for:

- Medical and dental expenses (including equipment, supplies and medications)
- Counseling expenses (for victims, for family members of homicide victims, and for children who witness violence against a family member)
- Funeral/burial costs up to $4,000
- Lost wages (for victims only)
- Loss of financial support (for dependents of homicide victims)
- Homemaker expenses
- **Expenses not covered**: property losses, compensation for pain and suffering, and all other losses

HOW DO I APPLY?

- Complete the application and return it to the Victim Compensation and Assistance Division for verification. In general, you will receive a decision 4 to 6 months later.
- Your claim can be reopened for future expenses.

Application For Crime Victim Compensation

(Please print legibly and fill out both sides)

VC #.

I. Victim Information

Victim's name _____ Female _____ Male _____

Mailing address _____ Home telephone (___)_____

City/State _____ Zip_____ Work telephone (___)_____

Date of birth _____ Age at time of incident _____ SSN ___-___-___

II. Applicant Information

(If victim is applicant, write "same"; if under 18, application must be completed by parent or guardian)

Applicant's name _____ Female_____ Male _____

Mailing address _____ Home telephone (___)_____

City/State _____ Zip_____ Work telephone (___)_____

Date of birth _____ Relationship to victim _____ SSN ___-___-___

If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s)_____

III. Crime Information

Type of Crime:

- ☐ homicide
- ☐ domestic violence
- ☐ stalking
- ☐ assault (non-familial)
- ☐ sexual assault
- ☐ child physical or sexual assault
- ☐ drunk driving
- ☐ other vehicular crimes
- ☐ kidnapping
- ☐ armed robbery
- ☐ arson
- ☐ other _____

Exact location of crime _____ City/State_____

Date of crime _____ Date crime reported _____

(If NOT reported within 5 days, please explain why in attached statement)

Name of Police Department _____ Investigating Officer _____

Name(s) of person(s) who committed crime (if known) _____

If you have been assisted by a victim advocate in the court/district attorney's office, provide name and telephone number of advocate_____

Briefly describe the crime and any injuries which resulted _____

_____

_____

_____

IV. Expenses

Check types of expenses for which you seek compensation:

- ☐ medical services*
- ☐ medical supplies/pharmacy*
- ☐ dental services*
- ☐ homemaker expenses*
- ☐ lost wages (for victim only)
- ☐ loss of financial support (for dependents of homicide victims)
- ☐ funeral/burial*
- ☐ counseling for victim*
- ☐ counseling for family members of homicide victim*
- ☐ counseling for children who witness violence against a family member*

***attach copies of bills and/or receipts**

Name/address of Funeral Home:_____

V. Lost Income (complete if seeking lost wages or loss of support)

Victim's employer _____ Contact person _____ Telephone _____

Address _____ City/State _____ Zip _____

If victim has or will return to work, estimated period of disability _____

If requesting financial support for dependent(s) of a homicide victim, provide the following information:

Name(s) of dependent(s)	Date of birth	SSN	Relationship to victim
		- -	
		-	
		- -	
		- -	

IV. Other Sources of Financial Assistance Check all potential sources of full or partial payment of expenses:

- ☐ health insurance
- ☐ life/accident insurance
- ☐ automobile insurance
- ☐ hospital-based "free care"
- ☐ unemployment benefits
- ☐ disability benefits
- ☐ other (please specify) _____
- ☐ workers compensation
- ☐ public benefits (welfare, medicare, medicaid, SSDI)
- ☐ restitution

Names and addresses of applicable insurance companies: _____

Have you filed or do you intend to file a civil lawsuit? Yes _____ No _____ Not Sure _____

If yes: Attorney's name _____ Telephone _____

Address _____ City/State _____ Zip _____

VI. Optional Information (For statistical purposes only)

Race/ethnicity of victim:
☐ White ☐ Black ☐ Hispanic ☐ Native American
☐ Asian/Pacific Islander ☐ Other ☐ I decline to answer this question

Who referred you to Victim Compensation? _____

Acknowledgement and Information Release

I understand that the Victim Compensation Fund is a fund of last resort. I agree to inform the Division of any funds I may receive from any source for losses for which I have requested compensation, and to promptly reimburse the Commonwealth for any such funds I may receive.

I give permission to any hospital, medical facility, doctor, mental health provider, insurance company, employer, person or agency to give needed information to the Victim Compensation Division. I understand that the information will be used to determine my claim for victim compensation benefits. I do not authorize the use or release of this information to any person or entity for any other purpose whatsoever. A photocopy of this signed release is as valid as the original. This authorization shall expire upon final determination of all requirements under G.L. c. 258C and 940 CMR 14.00.

I certify, under the pains and penalties of perjury, that all information and supporting documentation contained in this application is true and accurate to the best of my knowledge and belief.

X _____ Date _____

Applicant signature (parent or guardian if victim is a minor)

Return completed application to: **Office of the Attorney General, Victim Compensation & Assistance Division**
One Ashburton Place, 19th floor, Boston, MA 02108-1698. (617) 727-2200

The Commonwealth of Massachusetts
Executive Office of Public Safety
Criminal History Systems Board
200 Arlington Street, Suite 2200
Chelsea, Massachusetts 02150
(617) 660-4600
Fax: (617) 660-4613

ARGEO PAUL CELLUCCI
Governor

JANE SWIFT
Lieutenant Governor

JANE PERLOV
Secretary

MAUREEN W. CHEW
Executive Director

NOTICE OF AN OFFENDER'S RELEASE

A. WHO IS ELIGIBLE TO RECEIVE NOTICE OF AN OFFENDER'S RELEASE?

(1) The **Victim Rights Law (M.G.L. c.258B)**, mandates that victims, witnesses, family members of homicide victims and parents/guardians of minor aged victims shall, **upon request**, be notified, **in advance**, by the appropriate custodial authority *whenever the offender is **transferred** to a less secure facility, **escapes** from custody or **receives** a temporary, provisional, or final release.*

(2) The **Criminal Offender Record Information (CORI) Law (M.G.L. c.6, s.172c)** mandates that any person who reasonably believes that his/her safety is at risk by an inmate shall, **upon request**, be notified under a **C**itizen's **I**nitiated **P**etition (**CIP**). A written statement is <u>required</u> under the CIP process stating why the applicant believes the inmate might harm him/her.

B. WHY IS CERTIFICATION NEEDED TO RECEIVE NOTICE?

Certain offender information is protected from dissemination under the CORI law. The 1992 amendment to the CORI Law (M.G.L. c.6, s.172, p.6) allows custodial authorities to release, upon request, inmate placement and custody status information to the general public. However, certification allows the custodial authority to directly notify the certified person of the offender's transfer to a less secure facility, release, or escape from custody.

C. HOW IS CERTIFICATION OBTAINED?

Certification occurs **after** the offender is sentenced to incarceration to an ***<u>adult</u>*** county or state correctional facility. Applications are completed by the applicant with the assistance of a Victim Witness Advocate from the District Attorney's Office or the Victim Service Units of the Massachusetts Parole Board, Massachusetts Department of Correction (DOC) and the Criminal History Systems Board (CHSB).

Applications are submitted to the CHSB which is responsible for ***<u>approving</u>*** all certifications. To insure timely certification and notification, applications should be made immediately following the disposition of the criminal case. ***Offenders are not informed of an individual's certification status.***

D. WHAT HAPPENS AFTER A CERTIFICATION?

The Victim Service Unit at the CHSB sends a certification letter to the applicant verifying their certification status. The CHSB informs the county or state facility where the offender is incarcerated ***<u>and</u>*** the Massachusetts Parole Board of the certified person's right to notice.

(Handout Revised 3/00)

E. WHO ACTUALLY PROVIDES THE NOTICE?

Notice comes directly from either the correctional facility where the offender is housed ***or*** from the Massachusetts Parole Board ***depending on the inmate's release status.*** If the inmate is granted parole, then notice is given by the Massachusetts Parole Board. If the offender is completing his/her sentence, then notice is given by the Records Department at the correctional facility.

F. WHEN IS NOTICE GIVEN?

Notices are given whenever the offender is ***transferred*** to a less secure facility, ***escapes*** from custody or ***receives*** a temporary, provisional, or final release date. These releases include parole, emergency escorted leaves, work release, pre-release and final discharges.

G. WHO ANSWERS QUESTIONS ABOUT AN OFFENDER'S POTENTIAL PAROLE?

Any and all questions regarding the parole process should be directed to the Victim Service Unit at the Massachusetts Parole Board at (617) 727-3271. They can answer questions about parole eligibility, parole hearings, parole decisions, parole releases, conditions of parole and parole supervision.

H. WHO ANSWERS QUESTIONS ABOUT AN OFFENDER INCARCERATED IN A STATE PRISON WITH THE DEPARTMENT OF CORRECTION (DOC)?

Any and all questions regarding the placement and status of a state inmate should be directed to the Victim Service Unit at the Massachusetts Department of Correction at (978) 369-3618.

I. WHO ANSWERS QUESTIONS ABOUT AN OFFENDER INCARERATED AT A COUNTY BASED HOUSE OF CORRECTION (HOC)?

The Houses of Correction are operated by the county Sheriff's Departments. If you want to know what security level the offender has been under, ask to speak to the Classification Department. If you want to know when an offender is completing his sentence, ask to speak to the Records Department. If you experience difficulty in obtaining this information, the Victim Service Unit at the CHSB can provide assistance and intervention into the **county-based inquiries.**

J. WHAT IF THE CERTIFIED PERSON'S CONTACT INFORMATION CHANGES?

It is imperative that the certified individual inform the Criminal History Systems Board of any changes regarding their name, address, or telephone numbers. **NOTICE CANNOT BE GIVEN WITHOUT THE PROPER CONTACT INFORMATION.** The CHSB will forward the new contact information to the proper custodial authorities. Contact information is kept ***confidential.***

If you have any questions regarding the certification and notification process, please call the Victim Service Unit at the Criminal History Systems Board at (617) 660-4690.

(Packet Revised 3/00)

APPLICATION FOR NOTICE OF AN OFFENDER'S RELEASE

1). **The Victim Rights Law** (M.G.L., c. 258B), mandates that victims, witnesses, family members of homicide victims and parents/guardians of minor aged victims shall, **upon request**, be notified, in advance, by the appropriate custodial authority whenever the offender is transferred to a less secure facility, escapes from custody or receives a temporary, provisional, or final release.

2). The **Criminal Offender Record Information (CORI) Law** (M.G.L. c.6, s.172c) mandates that any person who reasonably believes that his/her physical safety is at risk by an inmate shall, **upon request**, be notified, in advance, of an offender's release under a Citizen's Initiated Petition" (**CIP**). Under the **CIP** process, you must provide a written statement with this application explaining why you believe the inmate might harm you.

INMATE INFORMATION

Probation Central File (PCF) #:		
Name of Inmate:	Alias(es):	
DOB:	SSN:	Race:
Charges:		
Sentence:	Date of Sentence:	
CURRENT Place of Incarceration:		

APPLICANT INFORMATION ***Applicant must be over 17 years of age***

Applicant (Ms./Mr.):	DOB:	SSN:	
Address:	City:	State:	Zip:
Home Phone: ( )	Business/Other Phone: ( )		
Special Needs (i.e., non-English speaking):			

YOU ARE APPLYING AS:

1. [ ] **Victim** [ ] **Witness** [ ] **Family member of homicide victim** [ ] **Parent/Guardian of minor aged victim**
2. [ ] **Citizen's Initiated Petition** ***(a statement must be provided for #2)***

IF APPLICANT IS NOT THE VICTIM

Victim's Name:	DOB:
Applicant's relationship to victim:	

****APPLICANT'S SIGNATURE**_____

ADVOCATE INFORMATION

Name:	Office:	Court:
Address:	Phone: ( )	Fax: ( )

(Revised 10/99)

Criminal History Systems Board
200 Arlington Street, Suite 2200, Room 2112
Chelsea, MA 02150
Phone: (617) 660-4690, Fax: (617) 660-1090

POST-CONVICTION VICTIM NOTIFICATION

ELIGIBILITY

M.G.L. C.258B, s.3(t) - Victim Rights Law	M.G.L. C.6, s.172(c) - CORI Law
Victims **Witnesses** **Family Members of Homicide Victims** **Family Members of Incompetent Victims** **Parent/Guardian of Minor Aged Victims**	**Citizen's Initiated Petition - "In fear of"**

NOTIFICATION REQUIREMENTS

A Summary Pursuant to M.G.L. c.258B, s3(t), M.G.L. c.6, s172(c) and 803 CMR 9.00
*All notifications are conducted by **telephone and mail**.*

14 DAY ADVANCE	AS SOON AS POSSIBLE	EMERGENCY
Transfer to less secure status including minimum status, pre-release status, electronic monitoring and day reporting **Transfer to out of state facility** if victim resides in that state **Temporary releases** including work release, program related activity, furloughs, speaking engagements and educational releases *All above includes descriptions of activities, general location of releases and transfers, level of supervision and to receive and consider input from victim **Parole**, pardon or commutation hearing **Projected parole release date** **Final Release** upon sentence completion **Final release notification to include any from and after sentences or civil commitments or terms of probation	Death of the inmate Return to higher custody Transfer from one county to another county Transfer from county facility to a state facility Court ordered releases including appeals or revised and revoked sentences	Escapes Emergency releases under escort Certification is generated within a 14 day time frame Receipt of court ordered pre-trial credits prohibits 14 day advance notification Breach of confidentiality

Certifications are confidential, disclosure of the existence of such is prohibited and access to certification information is limited to those staff persons who are responsible for providing notification.

APPLICATION FOR ACCESS TO C.O.R.I. DOCUMENTS

The **Criminal Offender Record Information (CORI) Law (M.G.L. c.6, s.178A)** ***mandates*** that victims, witnesses, family members of homicide victims, and parents/guardians of minor aged victims (as defined by the Victim Rights Law, M.G.L. c.258B) shall, upon request, be certified ***to receive CORI from criminal justice agencies regarding the criminal case which pertains to them.***

In addition, criminal justice agencies **may** also, in their discretion, disclose CORI relating to other offenses committed by the offender. They may also disclose an offender's **evaluative (mental health) and intelligence (investigative) information** which is not considered to be CORI. The criminal justice agency **may** disclose this discretionary information if they deem it necessary for the security and well being of the "178A certified person."

CORI is certain documentation and information held by criminal justice agencies regarding an offender's crime, arrest, prosecution, conviction, incarceration, probation and parole.

*****Applicants must provide criminal justice documentation to verify their eligibility status to receive CORI under M.G.L. c.6, s.178A.*** Documentation can include, but is not limited to, a brief statement from the victim witness advocate/prosecutor involved in the case, copies of any documents or letters issued by the court or District Attorney's Office, and police reports.

OFFENDER INFORMATION

Name:	DOB:	Social Security #:
*Date of Crime:	Charges:	
Docket #:	Probation Central File #:	
Sentence:		Date of Sentence:

APPLICANT INFORMATION

Name:	DOB:	Social Security #:
Mailing Address:		
Home Phone: ( )	Business/Other Phone: ( )	
Victim's Name (if not applicant)	DOB:	Relationship to Victim

YOU ARE APPLYING AS:

[ ] Victim [ ] Witness [ ] Family member of homicide victim [ ] Parent/Guardian of minor aged victim

Do you want to receive a copy of the offender's criminal record? YES NO

Applicant's Signature:_____ **Date:**_____

Victim Witness Advocate:_____ **Court:**_____ **Phone:**_____

Criminal History Systems Board
200 Arlington Street, Suite 2200, Room 2112
Chelsea, MA 02150
Phone: (617) 660-4690 Fax: (617) 660-1090

(Revised 3/00)

Massachusetts Parole Board
VICTIMS SERVICE UNIT

LISTENING TO VICTIMS

Too often victims of crime feel that their needs are ignored by the criminal justice system. For many, it seems that the offender has all of the rights while too little attention is paid to those whose lives have been disrupted by another person's criminal action.

This pamphlet explains what the **Massachusetts Parole Board** is doing to give victims a voice in the system and to reassure every member of the community that their concerns matter. The Parole Board recognizes that the decisions it makes affect victims and the community as well as the offenders. The following information tries to answer some of the questions that victims and their families are most likely to have about the parole process. **Victims and their family members are encouraged to call the Victims Service Unit for more information and assistance.**

WHAT IS PAROLE?

Parole is a portion of an offender's sentence that may be served in the community, under supervision, after a period of incarceration. Not all offenders are selected for parole release. Those individuals selected for parole must follow rules and conditions or behavior that are ordered by the Parole Board. Parole officers in the community supervise all offenders who are released on parole. In this way, the Parole Board strives to protect society by managing the sometimes difficult transition from incarcerated inmate to an individual who is a law-abiding citizen.

Parole is a conditional release. When granting parole release, the Parole Board may impose such conditions as "no contact with victim" or "must participate in counseling". **An offender who violates the conditions of parole may immediately be returned to custody.** Such return does not necessarily depend upon a new conviction or further court action.

WHEN WILL THE OFFENDER BE CONSIDERED FOR PAROLE?

The **parole eligibility date** is a point in the sentence when the offender may be considered for parole release. Sometime before reaching the parole eligibility date, the offender will be given a parole hearing. Being eligible for parole does not guarantee that the offender will be released on parole.

The type and length of sentence that the offender received determines the parole eligibility date. There are two basic types of sentences, House of Correction and State Prison. Parole eligibility for **house of correction** sentences is equal to one-half of the committed portion of the sentence or two years *whichever is less.* When the crime was committed after July 1, 1994 and the offender received a **state prison sentence**, the parole eligibility is the minimum number of years in the sentence, *minus any earned good time the offender may have accrued through program participation.* Questions regarding parole eligibility dates for offenders with

state prison sentences for crimes committed prior to July 1, 1994 may be directed to the Victims Service Unit.

The parole eligibility date is **tentatively** calculated at the beginning of the offender's period of incarceration. Offenders serving sentences less than sixty (60) days are not eligible for parole. Offenders serving some mandatory sentences, that the law says are mandatory, may not be eligible for parole. Offenders who are serving first degree life sentences are not eligible for parole. Most offenders are eligible to advance the parole eligibility date to an earlier time through program participation.

HOW ARE PAROLE DECISIONS MADE?

Except for life sentences, all sentences are time limited. This means that most offenders will eventually be released from custody either through parole release or at the end of the sentence. When an offender is released on parole, that person is supervised by a parole officer and must comply with rules and conditions of behavior. In some cases, it may be better for both the offender and the community to have the offender be released on parole with a period of supervision rather than allow the offender to complete the sentence and be released without supervision. However, the Parole Board will not grant parole release to an offender who is believed to be a significant risk to the community.

In an effort to determine whether an offender may present a risk to re-offend, the Parole Board reviews all available information prior to conducting a parole hearing. The Parole Board receives official information from the courts, District Attorney's offices, correctional facilities and probation departments. Some of the factors which the Parole Board looks at are: the nature of the present offense, prior criminal history, behavior during the incarceration, prior probation or parole failure, remorse and responsibility for the offense, community support and community opposition. In addition to a review of documents, the parole hearing includes an interview of the offender.

HOW MAY VICTIMS AND MEMBERS OF THE COMMUNITY PARTICIPATE?

Parole hearings that are conducted for inmates serving second-degree life sentences and for those seeking commutations or pardons are the only hearing which are open to public attendance. Parole hearings conducted for state prison inmates for crimes that resulted in a death are open to attendance by the surviving family members. Although victims and family members may not attend parole hearings for other types of sentences or offenses, the Parole Board provides other opportunities for them to communicate feelings and concerns about parole release.

The Parole Board will carefully consider any information that a victim wishes to provide. This information may include: **a brief overview of the crime, any fears or concerns about the offender or possible parole release, and any long-term effects from the crime**. The Parole Board does not require a formal **Victim Impact Statement** but will accept information in any form and from any source. Letters from victims, family members, neighbors and therapists may be submitted. Photographs, newspaper articles, and medical reports are also accepted.

It is important to submit information in advance of an offender's parole hearing. **Victims and others may request that their information be kept confidential if they have concerns for their safety.** *Please submit information to the Victims Service Unit at the address below.*

WHAT INFORMATION ABOUT THE OFFENDER MAY I OBTAIN?

The Criminal Offender Record Information (CORI) legislation prevents the release of some information regarding offenders. However, under the Massachusetts Victim Bill of Rights an individual who is the *victim, witness, parent or guardian of a minor victim, family member of a homicide victim or a person who has reason to fear for their safety*, may apply for **automatic notification** about certain changes in an offender's status. In order to receive automatic notification, it is necessary to complete an application. **The Victims Service Unit is available to assist with the CORI application process.**

Automatic notification from the Parole Board includes advance notices of

- the offender's tentative parole eligibility date,
- the date of a scheduled parole hearing,
- the Parole Board's decision, and
- when parole is granted, the offender's supervising parole officer and parole conditions.

Individuals who need to obtain additional information about the offender may contact the Victims Service Unit.

WHO MAY I CONTACT FOR INFORMATION OR ASSISTANCE?

Since 1987, the Parole Board has provided **information, support and referral services** to victims, witnesses and their family members through the ***Victims Service Unit***. The unit staff is trained to respond to questions and concerns that victims may have about parole issues. Victim Advocates are available to assist victims in communicating their concerns to the Parole Board and to provide referrals to community and criminal justice agencies. The *Domestic Violence Intervention Project* provides specialized assistance to victims of domestic violence and sexual assault.

A Victim Advocate is available to speak with individuals by telephone or in-person weekdays at the Parole Board's Central Office, from 8:45am to 5:00pm. If necessary, a Victim Advocate will arrange a meeting at one of the nine regional parole offices in the Commonwealth.

For information or assistance, please call or write:

Victims Service Unit
Massachusetts Parole Board
27-43 Wormwood Street
Boston, MA 02210-1606
Phone (617) 727-3271
Fax (617) 727-2753

A Message from the Commissioner...

Dear Friend:

The primary mission of the Massachusetts Department of Correction is to ensure public safety. Victim safety is public safety, and the Department is committed to providing victims, witnesses, and other concerned parties with quality assistance throughout an inmates incarceration. Following my appointment as Commissioner on August 1, 1997, I made the expansion of our Victim Service Unit (VSU) one of my top priorities. More than half of the 10,000 plus inmates in the Department's custody have been convicted of a violent offense. For every such inmate, there is at least one victim.

Recognizing the need to provide victims with the personalized assistance they deserve, the VSU expanded in the Spring of 1999 with the addition of five victim advocates. The Unit has also relocated from Boston to West Concord just off Route 2. The new location — only minutes from Route 495 and Interstate 95 — offers easy access from all parts of the state. The expansion and relocation of the VSU would not have been possible without the leadership and support of Governor Paul Cellucci, whose commitment to public safety and victim rights has been unwavering.

In addition to informing you about the VSU's expansion and relocation, I am pleased to introduce our new and improved Victim Service Handbook. This resource has been designed to provide you with post-conviction information, help you better understand the corrections process, and affirm your rights as a victim. For additional information, please call the number located on the front cover of this handbook.

The VSU is staffed by dedicated and compassionate victim service professionals who are eager to assist you. I invite you to contact the VSU to ask questions, express your concerns, or are in need of assistance. The Department of Correction welcomes your involvement in this stage of the criminal justice process. We look forward to hearing from you.

Sincerely,

Michael T. Maloney
Commissioner

Victim Service Unit's Mission

The primary mission of the Victim Service Unit (VSU) is to provide information, assistance, and support to victims of crime and other concerned parties whose offenders are in the custody of the Massachusetts Department of Correction (DOC). These services will be administered with respect, compassion, and confidentiality.

This mission is in conjunction with the mission of the Department of Correction, which is to promote public safety by imprisoning convicted felons while providing opportunities for rehabilitation through a structured reintegration model.

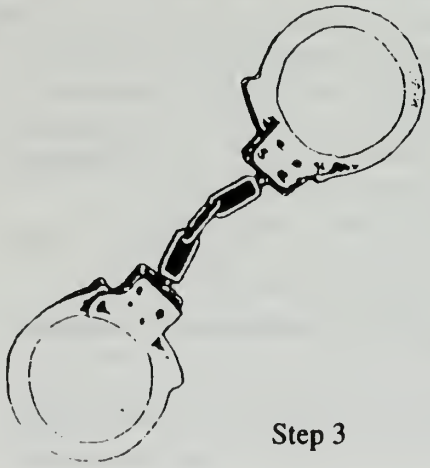
In addition to helping victims of crime, the VSU is available to victim service groups and state agencies for public speaking and training.

Introduction

On November 14, 1994, the Massachusetts Department of Correction established its Victim Service Unit. The VSU provides victims and other CORI-certified individuals with post-conviction information, emotional support, crisis intervention, safety planning and referral services.

This handbook was developed to help answer basic questions and concerns pertaining to the Department of Correction, the inmate, and your rights as a victim. If you are in need of assistance, please contact the VSU at (978) 369-3618 and ask to speak with a Victim Advocate.

What Happens To An Inmate After Sentencing?



Step 1

Offender Receives State Prison Sentence & Placed in DOC Custody

Step 2

Males Transported to MCI Concord; Females to MCI Framingham

Step 3

Initial classification lasts 3-6 months

Step 4

Transferred to prison facility deemed most appropriate for custody & program needs

Step 5

Receives re-classification hearing every 3-6 months

Sentence Reduction

Statutory Good Time

Most inmates who committed their crime/s prior to July 1, 1994 are eligible to receive statutory time. Statutory credit is an ***automatic*** sentence reduction based on an inmate's sentence structure and can range from 2.5 to 12.5 days per month. These credits, however, may be forfeited from the inmate for certain disciplinary infractions.

NOTE: Inmates who *committed* their crime/s after July 1, 1994 are not eligible to receive statutory time.

Statutory Time Exemptions

* Life Sentences
* Certain Mandatory Sentences
* Certain Drug Law Convictions
* Most Sex Offenders

Earned Good Time

Unlike statutory time, this type of credit must be earned. Inmates may reduce 2.5 to 7.5 days a month off their parole eligibility, minimum, maximum, and good conduct (GCD) dates. The total number of credits is then subtracted from all sentencing dates to arrive at new adjusted dates.

Earned Good Time can be achieved in three ways:

1) **Rehabilitation Programs**

2) **Education**

3) **Work**

An inmate may receive 2.5 days in each of the above categories for a maximum total of 7.5 days per month.

Earned Good Time Exemptions

* Life Sentences
* Certain Mandatory Sentences

Victim Notification

As a victim, family member of a victim, witness, or other concerned party, it is important to understand that CORI certification is the only means by which you will receive *automatic* notification of certain changes in the custodial status of an offender.

Please be aware that several criminal justice agencies in Massachusetts are responsible to provide CORI notification. It is the responsibility of The Department of Correction to notify CORI-certified individuals when an inmate:

- **Transfers to an institution with a security rating lower than Level 4**
- **Returns to higher security from Level 1, 2, or 3**
- **Receives a final release date**
- **Receives an emergency escorted release**
- **Dies**
- **Escapes**

NOTES:

***Notifications are not made when an inmate transfers from one Secure Facility to another. Victims are, however, encouraged to contact the VSU for periodic updates of an inmate's location.**

***To confirm whether or not you are CORI-certified or to apply for CORI-certification, please contact us at (978) 369-3618. Once you become CORI-certified, it is essential that you inform us if you change your address and/or phone number in order to ensure proper and timely notification. Certification entitles one to receive additional information regarding an offender *upon request.* For details regarding the types of subsequent information to which you may be entitled, please contact the number above.**

Other Frequently Asked Questions

Will I be notified of the inmate's upcoming parole hearing?
Can I let the parole board know how I feel about a possible release on parole?
For information about victim impact statements and/or an inmate's parole status, please contact the Massachusetts Parole Board at (617) 727-3271, and ask to speak with a Victim Advocate.

What should I do if I am receiving unwanted contact from an inmate?
You should contact the Department of Correction Victim Service Unit as soon as possible at (978) 369-3618, and we will assist you.

If I become CORI-certified, will the inmate know that I am certified or know my address and personal information?
No. CORI information is confidential and is not released to inmates at any time or under any circumstances.

The judge sentenced the offender to MCI-Walpole. Why isn't he incarcerated there?
Judges do not sentence offenders to specific prison facilities. A judge will sentence an inmate to serve either a County or a State Sentence. A "Walpole Sentence" is a term used by the courts to indicate a state prison sentence. The Department of Correction determines where an offender will be incarcerated through the classification process (please see page 3).

Why can an inmate reduce time off of his/her sentence?
Legislation passed by the Massachusetts Legislature allows most inmates to reduce their sentence/s (please see page 4). Since sentence reduction is mandated under Massachusetts Law, the Department of Correction is responsible for recording and calculating such credits.

Secure Facilities

A physical barrier (fence or wall) exists at *every* secure facility to prevent escape and control inmate movement. In addition, armed corrections officers are either stationed in watch towers located along a facility's outer perimeter or conduct vehicle and/or foot patrols.

Baystate Correctional Center, Norfolk, MA — Level 4 (male)
Bridgewater State Hospital, Bridgewater, MA — Level 4 (male)
Massachusetts Boot Camp, Bridgewater, MA — Level 4 (male)
Massachusetts Treatment Center, Bridgewater, MA — Level 4 (male)
MCI Cedar Junction, Walpole, MA — Level 6 (male)
MCI Concord, Concord, MA — Level 4 (male)
MCI Framingham, Framingham, MA — Level 4 (female)
MCI Shirley-Medium, Shirley, MA — Level 4 (male)
MCI Norfolk, Norfolk, MA — Level 4 (male)
North Central Correctional Institute, Gardner, MA — Level 4 (male)
Old Colony Correctional Center, Bridgewater, MA — Level 5 (male)
Shattuck Hospital Correctional Unit, Jamaica Plain, MA — Level 4 (male)
Southeastern Correctional Center, Bridgewater, MA — Level 4 (male)
Souza Baranowski Correctional Center, Shirley, MA — Level 6 (male)

Security Designations

Level 6 (Maximum)
Level 5 (High Medium)
Level 4 (Medium)

What distinguishes one level of a Secure Facility from another?

Inmate Movement
Inmate Interaction
Program, Work, and Education Opportunities

Less Secure Facilities

Inmate movement and interaction is controlled by rules and regulations. The inmate has exhibited a period of non-violent behavior and is compliant with DOC rules and regulations. He/she responds appropriately to program recommendations and has no unresolved legal matters.

Boston Pre-Release Center, Dorchester, MA — Level 2 (male)
Hodder House Pre-Release Unit, Framingham, MA — Level 3 (female)
Longwood Treatment Center, Jamaica Plain, MA — Level 3 (male & female)
MCI Lancaster, Lancaster, MA — Level 3 (male & female)
MCI Plymouth, South Carver, MA — Level 3 (male)
MCI Shirley Minimum, Shirley, MA — Level 3 (male)
Northeastern Correctional Center (NECC), Concord, MA — Level 3 (male)
Park Drive Pre-Release, Boston, MA — Level 2 (male)
Pondville Correctional Center, Norfolk, MA — Level 3 (male)
Pre-Parole Residential Environmental Phase (PPREP), Level 1 (male & female
Southeastern Correctional Center Minimum, Bridgewater, MA — Level 3 (mal
South Middlesex Correctional Center, Framingham, MA — Level 2 & 3 (male

Security Designations

Level 3 (Minimum)
Level 2 (Pre-Release)
Level 1 (Halfway House & Electronic Monitoring)

What distinguishes one level of a Less Secure Facility from another?

Rules and Regulations
Inmate Supervision
Community Access

VICTIM RIGHTS LAW OF 1995

Provisions Pertaining to Probation of Offenders

Victims have the following rights:

- The right to confer with the **probation officer** prior to the filing of the full resentence report:
- The right to receive a copy of the schedule of restitution payments from the **probation department** as well as the name and phone number of the **probation officer** responsible for supervising payment by the offender:
- The right to receive notice from the **probation officer** and be heard at any hearing to Modify the restitution order:
- The right to receive from the prosecutor's office within 30 days a copy of the court order setting forth the conditions of probation with the name and phone number of the **probation officer** assigned to the defendant:
- Finally, the statute declares that police prosecutors, judges, **probation officers**, clerks and corrections officials shall assure that victims are afforded the rights set forth by this law.

A complete copy of the Victim Rights Law of 1995 can be obtained by calling the Massachusetts Office for Victim Assistance at (617) 727-5200.

Section D:
Understanding the Biological Basis of Trauma

Section D: Understanding the Biological Basis of Trauma

Panelists: **Dr. Bessel A. van der Kolk** (morning)
Director
The Trauma Center
16 Braddock Park
Boston, MA 02116
(617) 247-1720

Dr. Terence Keane (afternoon)
Chief of Psychiatry
Veterans Medical Center
150 South Huntington Avenue
Boston, MA 02130-4893
(617) 278-4551

Coordinator: **Rob Fleck**

20

Psychological and Behavioral Treatments of Post-Traumatic Stress Disorder

Terence M. Keane

Several Type 1 and Type 2 random clinical trials (RCTs) have confirmed exposure therapy (including systematic desensitization, flooding, prolonged exposure, and implosive therapy) and, to a lesser extent, anxiety management techniques (using both cognitive and behavioral strategies) as the psychosocial treatments of choice for post-traumatic stress disorder (PTSD).

Eye-movement desensitization and reprocessing (EMDR), a recently introduced approach to the treatment of PTSD, has shown some promise, although its research base to date, consisting largely of open clinical trials, is inadequate.

PHENOMENOLOGY

When individuals are exposed to life-threatening events or other catastrophic stressors, some can develop a persistent and potentially debilitating syndrome known as post-traumatic stress disorder (PTSD). The syndrome is often characterized by high levels of anxiety and depression, but its distinctive symptomatology includes (a) reliving experiences such as intrusive thoughts, nightmares, dissociative flashbacks to elements of the original traumatic event, and psychophysiological reactivity to cues of the traumatic event and preoccupation with that event; (b) avoidance of thoughts, people, and places that resemble the traumatic event, emotional numbing that is tantamount to an absence of emotional attachments, and an inability to feel the range of positive emotions that contributes to the complete human experience; and (c) symptoms of hyperarousal, including heightened startle sensitivity, sleep problems, attentional difficulties, hypervigilance, and the presence of irritability, anger, or rage (cf. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. [*DSM-IV*], American Psychiatric Association [APA], 1994).

PREVALENCE

Post-traumatic stress disorder occurs in contemporary society at high rates. Recent epidemiological studies indicate that in the United States prevalence rates for exposure to traumatic stressors may be as high as 70% of the adult population (Norris, 1992; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993); corresponding rates for the development of PTSD indicate that at least 8% of the general population ultimately develops PTSD (Breslau, Davis, Andreski, & Peterson, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Such estimates conservatively yield 20 million cases of PTSD (current or lifetime) in the United States alone. Perhaps most important is the recognition that violence in the home and the community continues

unabated in society, that almost daily we learn of newly occurring natural or technological disasters, and that the presence of armed conflicts across the world adversely affects the lives of many more individuals and their families.

General population statistics, of course, do not provide a comprehensive view of the nature of trauma exposure and PTSD. Inspection of special groups at elevated risk provides an important perspective on the depth of the problem. To do so, we must rely again on statistics from the United States since the strongest methodological studies have been completed there. Among American women, approximately 13% have experienced a completed rape; 31% of these women (for a total of about 4% of the general population) developed PTSD following the assault (Kilpatrick, Edmonds, & Seymour, 1992).

Similarly, in the most comprehensive study of the effects of war on its combatants, the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990) found a lifetime rate of PTSD of 30% and a current rate of PTSD of 15%. Moreover, in a national study of women, Resnick et al. (1993) estimated prevalence rates of current PTSD to be 5%, with lifetime rates of 12%.

Examination of the rates of trauma exposure and PTSD across studies does yield interesting gender differences. It seems that while men report higher rates of exposure to traumatic events, women report more PTSD. Many possible explanations exist for these observed differences. Women may be more susceptible to PTSD due to a possible link to factors associated with the gender differences in depression. Alternatively, the types of stressors to which women are differentially exposed (e.g., sexual assault) may be those most strongly related to the development of PTSD irrespective of gender. More research to illuminate further the underlying factors responsible for these observations is clearly needed.

ETIOLOGY

While the occurrence of a traumatic event that evokes feelings of terror, horror, or helplessness is essential for conferring the diagnosis of PTSD, it is clearly only one of the factors associated with the development of PTSD. Clearly, not everyone exposed to a potentially traumatic event develops PTSD. To explain this, psychopathologists have evoked the concept of individual differences. The classic paradigm on the effects of life stressors, initially proposed by Dohrenwend and Dohrenwend (1981), indicates the relative importance of (a) the stimulus component of the stressor in affecting outcome, (b) the ongoing situational context within which the event occurs, and (c) the personal characteristics, including biological and psychological factors, exposure to previous traumatic events, and an individual's coping style in the development of PTSD.

King, King, Foy, and Gudanowski (1996) conducted supplementary analyses of the NVVRS data in an effort to understand more fully the etiological factors associated with the development of combat-related PTSD. These analyses identified wartime traumatic stressors as the primary contributor to PTSD, as predicted. They also found that prior exposure to traumatic events, age at the time of combat exposure, and premilitary family instability added significantly to their understanding of who develops PTSD, as did postmilitary factors such as social support, the presence of additional life stressors, and personal hardiness.

While many factors are involved in the etiology of PTSD, Sutker, Allain, and Johnson (1993) provided a brilliant example of the primary importance of trauma exposure in the development of PTSD. In a case study, two identical twins who were raised, educated, and trained together as aviator pilots, but who were discordant for combat exposure and prisoner-of-war status, were administered a comprehensive psychological and neuropsychological examination. The results indicated that the former POW reported symptoms of PTSD, several other psychiatric diagnoses, intellectual performance deficits, as well as significant cognitive defects. None of these was observed in his identical twin. The findings point directly to the pathogenic effects of war zone stress exposure.

Clearly, the etiology of PTSD is a complex phenomenon. To appreciate fully the factors involved in its development requires an understanding of the event itself, the context in which the event occurs in the life of the individual, the resources and deficits the individual brings to it, as well as the post-trauma environment. Advances in structural equation modeling have helped us to begin to understand how, in aggregate, traumatic events affect the lives of those exposed (Fontana & Rosenheck, 1993; King et al., 1996).

HISTORICAL PRECEDENTS OF CURRENT PSYCHOLOGICAL TREATMENTS

Historically, the works of Janet (1889) and Freud (1936) have most influenced the treatment of PTSD. The objectives of each approach share much in common with contemporary models of treatment, and thus current treatments owe a substantive debt to these pioneers. As presented by Fenichel (1945), there are two components to the psychoanalytic treatment of "traumatic neurosis": (a) attempts to quiet the high levels of anxiety and reactivity to the event and (b) attempts to reconstruct the details of the event with the accompanying emotional reactions to promote mastery over memories of the event.

Janet's (1889) contributions, reanalyzed and discussed frequently since the inclusion of PTSD in the *DSM* in 1980, focus on the idiographic phenomenology and the psychological symptoms often observed in traumatized patients. The inclusion of hypnosis as a viable treatment for traumatized people added a systematic and technical approach to achieving the psychoanalytic objective of reconstructing details of the event in order to achieve mastery.

In the aftermath of World War II, the use of sodium amytal interviews to recreate and to recall details of traumatic war events became increasingly widespread. Again, the objective of these interviews was to identify critical elements of traumatic war events that were not reported by the patients so that efforts to address the psychological sequelae of these events could begin. Typically, the events involved human devastation, atrocities, anxiety in the face of death and danger, and helplessness.

Today, the issue of traumatic memories has entered contemporary study of PTSD, with some denying the idea that memories of traumatic events have distinctive characteristics in comparison to memories of other life events, some challenging the nature of the constructs often invoked to explain traumatic memories (e.g., dissociation or repression), while others are vigorously holding to scientific standards recognizing that work in this area has only attained the scientific status of clinical observation. Despite the debate, which has at times reached vitriolic dimensions, it is clear that thousands of clinicians over the lengthy history of psychotherapy have noted that, during therapy, traumatized patients do indeed come to understand the nature and details of past traumatic events, whether these events occurred in childhood, as in the case of incest, or in adulthood, as with war veterans. Additional research directly on the issue of traumatic memory would contribute immeasurably to our understanding of developmental psychopathology and to the treatment of PTSD.

CURRENT TREATMENTS OF CHOICE FOR POST-TRAUMATIC STRESS DISORDER

Largely driven by the psychological and social problems of returning American Vietnam veterans, mental health practitioners established treatment programs to treat traumatic disorders (e.g., Keane & Kaloupek, 1982). Concomitantly, clinical researchers began to understand more fully the psychological consequences of exposure to sexual assault and rape (Burgess & Holmstrom, 1974; Kilpatrick, Veronen, & Resick, 1979) and to develop treatments for these problems.

At the outset, conceptual models of PTSD borrowed from Mowrer's (1960) two-factor learning theory (Fairbank & Keane, 1982; Keane, Zimering, & Caddell, 1985; Kilpatrick, Resick, & Veronen, 1981), which posits that fear and other aversive emotions are learned through association via classical conditioning mechanisms. This is the first factor in the acquisition of aversive emotions. The second factor is that individuals will do whatever is necessary to escape from and to avoid cues that stimulate these aversive emotions.

Recent theoretical models have grown to increasingly accommodate cognitive factors (Foa, Steketee, & Rothbaum, 1989; Lang, 1977; Litz & Keane, 1989), yet the treatments that evolved from the two-factor learning theory model remain among those most widely practiced and researched. Specifically, exposure therapy and anxiety management techniques have evolved as two of the most accepted treatments for PTSD patients. Although group therapies, both structured and unstructured, and psychodynamically informed psychotherapy are also widely used to treat PTSD, there are few studies in the literature that document the clinical efficacy of these approaches. However, the parallels between the objectives of psychoanalytic approaches as delineated above and those of anxiety management and exposure therapy are unmistakable (i.e., directly reducing anxiety to cues of the event and mastering the memory).

A more recent approach to treating PTSD is eye-movement desensitization and reprocessing (EMDR; Shapiro, 1989). This is essentially an atheoretical technique that was accidentally discovered to alter disturbing thoughts, feelings, and images (Shapiro, 1995). It has been applied to a broad range of psychological problems, but the only available research on its efficacy is with PTSD, so it is discussed in this chapter. Accordingly, the focus of this section of the chapter on psychological treatments of PTSD examines the data supporting the use of exposure therapies, anxiety management therapies, their combination, and EMDR.

Exposure Therapies

There is a long, rich tradition for treating anxiety disorders with one or another of the exposure therapies, whether it be systematic desensitization, flooding, prolonged exposure, implosive therapy, or the like (e.g., Barlow, 1988; Levis, 1980; Rachman, 1980). Keane and colleagues were among the first to apply exposure therapy to the treatment of PTSD. Initially, this application took the form of single-subject designed studies to document the effects of systematic exposure to memories of the traumatic events experienced by combat veteran patients (Black & Keane, 1982; Fairbank & Keane, 1982; Keane & Kaloupek, 1982). Significant reductions in anxiety and other related symptoms were noted as a function of these interventions. These Type 3 studies were instructive because they employed a consistent conceptual model of PTSD in the implementation of a treatment, utilized systematic diagnostic measures for case identification, and measured outcome in replicable, standardized ways.

This preliminary work led to the development of a randomized clinical trial (RCT; Type 1) that compared two active treatments (exposure therapy and anxiety management therapy) to a waiting list condition in the treatment of combat-related PTSD in Vietnam veterans. The results of this study were clear-cut. Compared to the wait-list condition, those patients receiving imagery-based exposure therapy showed reductions on standard psychometrics and on clinician ratings of symptoms at the posttreatment assessment. Changes on these measures were maintained at a 6-month follow-up evaluation. Interestingly, the less-intensive treatment (anxiety management) experienced so many treatment dropouts that insufficient data were available for analyses (Keane, Fairbank, Caddell, & Zimering, 1989).

In the Netherlands, Brom, Kleber, and Defares (1989) also conducted a Type 1 RCT comparing three active treatments for 112 patients who had experienced a traumatic event and were seeking psychotherapy. The treatments were exposure therapy (i.e., systematic desensitization), hypnotherapy, and psychodynamic treatment. Patients were evaluated before treatment, immediately after treatment, and at a 3-month follow-up using standardized psychometric instruments. The patients receiving exposure therapy showed a reduction in symptoms at posttest that was maintained at the 3-month follow-up. While comparable levels of change were noted in the other two active treatment groups, all three groups demonstrated greater change than the waiting list condition.

In possibly the most methodologically rigorous Type 1 RCT for PTSD, Foa, Rothbaum, Riggs, and Murdock (1991) examined exposure therapy, an anxiety management condition termed stress inoculation, supportive counseling, and a wait-list condition for the treatment of rape-induced PTSD. Measures included clinical ratings of symptoms and standardized psychometric inventories, all administered at pretreatment, posttreatment, and at a 3.5-month follow-up. The stress inoculation treatment was superior to the counseling and wait-list conditions at posttest. However, at the follow-up the patients receiving exposure therapy performed the best on measures of PTSD compared to all other conditions.

Two additional studies with combat veterans with PTSD also demonstrate the salutary effects of exposure therapy. Boudewyns and Hyer (1990) and Cooper and Clum (1989), in Type 1 RCTs, demonstrated that the addition of exposure therapy to available treatments of PTSD improved outcome for patients.

In what may ultimately prove to be the most instructive lesson for the treatment of individuals exposed to traumatic events, Foa, Hearst-Ikeda, and Perry (1995) examined the efficacy of a brief intervention to prevent the development of chronic PTSD. For women who had been recently raped, the authors developed a program based on that which worked so well in earlier trials with chronic PTSD (Foa et al., 1991). Exposure therapy figured prominently in the package of treatments assembled. This package also included elements of education, breathing retraining, and cognitive restructuring. Compared to a matched control group, this Type 2 study found that at 2 months

postintervention only 10% of the treated group met criteria for PTSD, while 70% of the untreated comparison group did.

In another Type 2 study, Frank and Stewart (1983) reported the effects of systematic desensitization on women who had been raped and who developed significant psychological symptomatology. Compared to an untreated comparison group, those women treated with graduated exposure improved most on a range of anxiety and depression symptom measures.

Richards, Lovell, and Marks (1994; Type 2) compared imaginal and in vivo exposure in a randomized study of survivors of diverse traumatic events. At the 12-month follow-up, patients reported consistent reductions in PTSD symptoms and improved social adjustment. These data further substantiate the effectiveness of exposure therapy for some patients and also suggest that improvements in symptoms are also reflected in critical domains of life functioning.

In summary, the extant data support the use of exposure therapy in the treatment of PTSD. In a previous review of this literature (Type 5 study), Solomon, Gerrity, and Muff (1992) derived the same conclusion from data available at that time. Similar conclusions were drawn by Otto, Penava, Pollack, and Smoller (1996) in a more recent review (Type 5) of the literature.

As data continue to accrue on exposure therapy, there is a distinct need for studies to examine combinations of treatments, employ measures that assess social and occupational functioning, and employ a broader range of patient types (i.e., beyond combat and rape PTSD). At this time, samples examined in many of the studies have necessarily been small, so larger samples need to be treated.

Although definitive studies have not yet been conducted in this area, clearly the available efficacy studies demonstrate the value of extending exposure therapies to PTSD patients. With a rich tradition deeply rooted in experimental psychology and tested in the treatment of many anxiety disorders, exposure therapy in its many formats should be given priority by clinicians encountering patients with PTSD.

Anxiety Management Training

Typically, anxiety management training (AMT) involves teaching patients an assortment of behavioral and cognitive strategies to enhance their capacity to manage the emotions associated with PTSD. Such skills might be relaxation training, breathing retraining, trauma education, guided self-dialogue, cognitive restructuring, and communication skills training. Some programs for PTSD have emphasized the incorporation of anger management training as a part of the skills taught to patients (Chemtob, Novaco, Hamada, & Gross, 1997; Keane et al., 1989) given the saliency of this interpersonal problem among patients with PTSD.

Studies described above by Foa et al. (1991) and Keane et al. (1989) compared exposure therapy to AMT. In the Keane et al. study, therapists were instructed to explicitly avoid discussing or processing the traumatic events of the patients in an effort to minimize the amount of exposure provided in this treatment condition. Perhaps this severe restriction led to the high rate of dropouts in the AMT condition. While the treatment appeared to be face valid in its emphasis on treating the precise symptoms of PTSD, it evidently did not provide sufficient relief to the combat veterans enrolled in this trial. However, this treatment did result in significant reductions in symptoms for female rape victims in the Foa et al. (1991) study, as discussed above. The long-term effects were just not as strong as those found for exposure therapy.

Some studies primarily employed one form of AMT rather than a multifaceted treatment package. For example, Peniston (1986) conducted a Type 1 project examining the effects of biofeedback-assisted relaxation treatment for veterans with combat-related PTSD. This form of AMT did result in significant short-term positive effects for the experimental group.

Similarly, Chemtob et al. (1997) presented data on the treatment of anger and rage in PTSD veterans. Although the sample size of this Type 2 study was small, behavioral treatment employing an anger-focused version of AMT yielded impressive reductions on psychometric measures of anger and on laboratory measures (behavioral) of anger reactivity. Importantly, these changes were associated with reductions in reexperiencing symptoms of PTSD.

Clearly, there is evidence to suggest that a skills training approach such as AMT can have a favorable impact on symptoms of PTSD. While the data are neither as strong nor as consistent as those for exposure therapy, it seems reasonable to conclude that there is some empirical validation for the use of AMT in treat-

ing PTSD. Possibly the strongest potential application for treating PTSD is within a package combining exposure therapy with AMT. There are ample precedents in the mental health literature for combining techniques to yield stronger therapeutic effects (cf. Barlow, 1988).

Combinations of Exposure Therapy and Anxiety Management Training

Resick and Schnicke (1992) have proffered a multidimensional behavioral treatment package for women who have rape-related PTSD. This package, entitled cognitive processing therapy (CPT), combines elements of exposure therapy, AMT, and cognitive restructuring. In a Type 2 evaluation of CPT, the authors compared outcomes at pretreatment, posttreatment, 3 and 6 months for a treatment group, and a wait-list comparison group (no random assignment was used). On clinician ratings and psychometric inventories of PTSD, the patients receiving CPT improved markedly. At the posttreatment assessment, impressively, none of the treated patients met criteria for PTSD.

This form of psychological treatment combination promises to strengthen the resources available to clinicians to treat PTSD. Comparisons of CPT to exposure therapy are ongoing in this research laboratory and will evaluate the extent to which CPT leads to greater improvement than exposure therapy alone. Extensions of its use to other forms of PTSD will then be warranted.

Eye-Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a technique designed by Shapiro (1989, 1995) that has received considerable attention from practitioners and academics alike. Worldwide training institutes are well attended by clinicians seeking to learn about EMDR and its use in PTSD. While Shapiro (1995) alleges that this technique is helpful for treating a range of disorders, its use is often directly associated with PTSD.

Since the first publication described the technique (Shapiro, 1989), a series of single subject cases and open clinical trials has suggested that this approach to treating the psychological effects of trauma exposure may promote recovery. From an operational perspective, the essence of EMDR seems to be (a) the evocation of trauma-relevant images and memories, (b) the psychological evaluation of the aversive qualities of these images/memories, (c) the identification (with or without therapist assistance) of an alternative cognitive appraisal of the image/memory, (d) examination of physiological reactions to the image/memory, (e) focusing on the idiographically determined positive appraisal of the image/memory, and (f) repeated sets of lateral eye movements while the patient is focusing on elements of the traumatic response.

Examining the efficacy and effectiveness of EMDR is challenging. Its mechanism of action is not, realistically, based on any contemporary theories of human behavior, learning, or cognitive science, although some discussion of Pavlovian neurophysiology is provided across publications (Shapiro, 1989, 1995). For this reason, it has been seriously criticized in the scientific literature (Herbert & Mueser, 1992; Lohr, Kleinknecht, Tolin, & Barrett, 1995). Yet, the absence of theory or a conceptual foundation is not sufficient to dismiss totally the preliminary findings of the technique. If there is efficacy, then serious scholars can assume responsibility for identifying the precise mechanism responsible for any effects observed. The questions are, therefore, is there evidence for EMDR's efficacy? and, most importantly, is EMDR more effective or efficient than tested techniques?

Probably because EMDR is not based on any existing theoretical or treatment literature, there is a surprisingly large number of case studies in the literature. Reviewing this literature comprehensively is beyond the scope of this chapter. Rather, the focus is on those studies and reviews of the literature that provide the nexus for an evaluation. Only one of the existing studies meets criteria for a solid Type I designation (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1995). In that study, EMDR was compared to biofeedback-assisted relaxation training and routine clinical care. The authors reported that at the 180-day follow-up the group receiving EMDR showed greater clinical improvement than either of the two comparison groups on self-reported, psychometric, and clinician-rated measures of PTSD.

Wilson, Becker, and Tinker (1995; Type 2) reported on the treatment of traumatic memories in a heterogeneous sample of individuals recruited through newspaper advertisements and other means. Half of their subjects received EMDR, while the remaining

half were placed on a waiting list. Of the 80 subjects in this study, less than half reached *DSM* criteria for PTSD. Following three sessions of EMDR, the treated group demonstrated a greater reduction on psychometric measures and clinician ratings of symptoms than did the wait-list subjects.

Other studies on EMDR's efficacy have been less encouraging. Projects by Boudewyns, Stwertka, Hyer, Albrecht, and Sperr (1993), Jensen (1994), and Vaughan et al. (1994) found only modest effects for EMDR. These studies all have significant methodological limitations (Type 2 studies), but they are comparable in quality and design to those projects providing the empirical support for this technique. One study by Renfrey and Spates (1994; Type 2) found no differences between a group receiving the eye movements compared to a similar group that did not, thus challenging the eye movements' role in the treatment.

In summary, much work needs to be done before research will firmly support the use of EMDR for the treatment of PTSD. Unlike exposure therapy, which has a long tradition of ameliorating a range of anxiety-mediated clinical problems and is embedded in the rich conceptual tradition of experimental psychology, EMDR falters seriously at the theoretical level and has limited scientific support. Needed are basic studies to examine the effects of eye movements (or other laterally alternating stimuli), small-scale, well-controlled efficacy studies that meet contemporary standards for treatment outcome research, and the formulation of a testable theory for the technique. Implicit in this last recommendation is the development of a conceptual model of PTSD and how EMDR attempts to correct either the deficits or excesses involved in this disabling psychological condition.

In concluding this review of EMDR, it may be valuable to delineate the possible strengths of this technique. First, EMDR does share some components of exposure therapy and cognitive therapy. These overlapping components should be identified and be made operational to promote our ability to study the approach more fully. Second, the technique builds assessment into the ongoing therapy process. Third, EMDR suggests that instructions to modify images and alter cognitive self-statements may be a reasonable treatment objective for PTSD patients. Fourth, the training programs established for technique dissemination and supervision are enviable. And, fifth, Shapiro and colleagues have always promoted the need for empirical documentation to support their perspective on treating PTSD.

The primary weakness of EMDR stems from a distinct lack of integration with existing psychological models of psychopathology and psychotherapy. While existing models may have their own failings, it is incumbent on the proponents of EMDR to postulate how their view of the problems associated with PTSD differs from other views and how this technique can allay specific targeted symptoms of this multidimensional disorder.

Future Treatments of Choice

There is much to be learned about the treatment of PTSD. To be sure, there will be no simple answers for treating people who have experienced the most horrific events life offers. Undoubtedly, combinations of treatments as proposed by Keane (1995), Foa et al. (1991), and Resick and Schnicke (1992) may prove to be the most powerful interventions.

As these treatment packages are developed, there is a need for additional work from perspectives other than the cognitive-behavioral one. Interpersonal therapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) and other short-term psychodynamically informed treatments need to be developed, evaluated, and then compared to existing behavioral and cognitive-behavioral treatments to determine which patients benefit most from these methods.

Similarly, there is a need to develop psychopharmacological interventions further so that they can be compared and contrasted with effective psychological methods, both individually and in combination. The PTSD research in this area is only in the nascent stages of development.

Finally, there is an assumption of uniformity of traumatic events that strings throughout this review. While it is reasonable to speculate fundamental similarities among patients who have experienced diverse traumatic events and then develop PTSD, whether these patients respond to clinical interventions in the same way is an empirical question that has yet to be addressed. Studies posing a question such as this would be a welcome addition to the clinical literature.

The problems associated with war, rape, violence, criminal assault, and disaster do not appear to be declining. As a result, sound public policy is needed to guide society's response to survivors of these experi-

ences. Post-traumatic stress disorder in its most chronic form is a debilitating condition that affects individuals, their families, their communities, and the nation. Those who are the targets of violence may ultimately become perpetrators, thus contributing to the cycle of violence initially documented by Widom (1989). If this is so, then interventions need to be implemented to prevent the occurrence of violence (primary prevention) or to mitigate its effects once it occurs (secondary prevention). Reliance on sound empirical work to devise and implement these prevention efforts may ultimately be the best solution to the problems associated with PTSD.

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EMDR's supporters are reporting dramatic results

TOO GOOD TO BE TRUE?

RICHARD WEBSTER WALKED AWKWARDLY ON HIS PROSTHETIC shoes into psychiatrist David McCann's office in Salt Lake City on a hot summer day in 1991. His face was badly scarred from burns he'd suffered in a terrible mining accident. He had artificial arms, and he was deaf—a side-effect of the heavy doses of antibiotics that had kept him alive during a long hospital stay. The physical damage was serious enough. But it was his psychological suffering that had truly cast him into hell. For eight years, he had experienced the accident that had nearly taken his life not as past, but as eternally present.

Early in May 1983, Webster, then 33, was working in a silver mine on the Utah-Nevada border. He had been lowered into a narrow mineshaft to do some welding when gases below him ignited, and he was blown to the surface in a ball of flames. He spent the next two years in the hospital; since then, he had required nursing care 24 hours a day.

BY KATY BUTLER

Each night, he fell asleep feeling as though his scalp were on fire; every day, he saw himself burning and felt as though he were again gasping for air. He had nightmares; he couldn't sleep; he had trouble concentrating; he avoided television because he became so upset when he saw fires and explosions. He had refused Prozac and Thorazine because he believed they would suppress rather than cure what was inside him. He felt as though he was heading "for the rubber room at the lollypop farm." Like millions of other survivors of war, accident, incest and crime, he suffered from the intrusive thoughts, nightmares and flashbacks of PTSD—post-traumatic stress disorder.

McCann spent Webster's first two visits taking a careful history, communicating with the help of notes and Webster's skillful lipreading. Then McCann suggested they try a new technique he'd read about called Eye Movement Desensitization and Reprocessing (EMDR). It might not help, McCann said, but it probably wouldn't hurt; why not give it a whirl? Webster agreed, and McCann, using an approximate version of a method he had never seen demonstrated, pulled his chair up close to Webster's. He told Webster to hold three things in his mind: a single image from the accident (being consumed in the ball of fire); the associated emotion and body sensation (fear and an overwhelming adrenalin rush); and the related thought ("My God, I'm on fire"). Then, McCann moved his hand back and forth 20 times, while Webster tracked the movement with his eyes. Afterward, McCann told him to relax and report what came to mind.

A second vivid memory had flashed through Webster's mind: the sound of his wrench careening off the rocks on its way to the bottom of the mineshaft, and the thought, "I'm a dead man." Focusing on that memory, again Webster tracked McCann's moving hand. Another image arose: Webster's hard hat falling into the shaft, and the thought, "I have to get out of here." Once again, he held feeling, image and thought and flicked his eyes from side to side. Another image came: from a vantage point somewhere high above the scene, he saw himself lying on the ground in flames while his foreman cursed and his fellow workers cried out in horror. "My God," was the thought, "Do something to help me." Then a tangentially related image arose: an earlier, nearly fatal, work accident, when his tattered jacket had become entangled in a spinning drilling rig. After each memory arose, McCann repeated the deceptively simple procedure.

Then the terrifying and traumatic images left. Webster saw a calm and peaceful scene, as though he were floating on clouds. "I'm alive!" he thought. Although he was not a religious man, he later said that he realized "there are other dimensions in this universe—things don't just end here." Tears came to his eyes. He told McCann that he felt an almost overwhelming sense of peace.

A week later, Webster came back and told McCann his nightmares and flashbacks were gone. His scalp no longer burned. He could read, work on his computer, concentrate and watch television. "I just want to be as independent as I can now," he said. For the first time in eight years, he could do without a nurse for eight hours a day. He began to water his lawn in the evenings and to help prepare his own meals.

The next month, Webster passed a driving test, bought a car and drove around town feeling like a prisoner on parole. He told McCann, "A boulder was lifted off me." The next year, he drove across Utah to see his family, visited Canyonlands National Park, made friends with other amputees, and joined the board of directors of Child Reach Funding Program, an organization that helps provide prosthetic limbs to needy children.

"It was an amazing experience that defies imagination," Webster said recently, two years after his single, one-hour treatment with EMDR. "I concentrated on the most terrible things that had ever happened to me, and it all went away. "The treatment made me look deep—very deep—into my own existence. Now, I see very clearly the fragility of human life and what it means to me. I'm more attentive to my feelings. I treasure each and every moment of my life.

"Is the treatment wearing off? No, absolutely not. I will not allow it to get away from me. It's in me forever."

McCann wrote up the case for the *Journal of Behavior Therapy and Experimental Psychology* last year, another in a growing collection of favorable testimonials that have stimulated the rapid spread of EMDR. "This is something entirely new that operates according to principles we don't understand," says McCann, who usually specializes in drug therapy and short-term psychotherapy. "It's like the early days of antidepressants. EMDR seems to work, but we don't know how."

CASES LIKE RICHARD WEBSTER'S ARE the undeniable miracles of EMDR. Nobody understands them. The procedure seems ludicrous at first. It defies common sense to think that flicking the eyes back and forth can catapult someone into vividly reliving—and rapidly resolving—traumas that have ruled their lives for 20 years. No psychological or self-transformative tradition in history has made use of anything like it, aside from a few yoga exercises and one paper in a psychology journal in the 1950s by Baltimore psychiatrist Harry Teitelbaum, who noted that his patients flicked their eyes while concentrating.

It defies common sense to think that flicking the eyes back and forth can catapult someone into vividly reliving—and rapidly resolving—traumas that have ruled their lives for 20 years.

In its combined rapidity and emotional intensity, EMDR challenges most existing therapeutic paradigms: behaviorists say that repeated exposure is necessary to extinguish traumatic response; family therapists warn against focusing too much on the past and the identified patient; and psychodynamic clinicians believe that insight, time and a close therapeutic relationship are crucial for profound psychological change. And yet, if the stories told over the past five years are true, EMDR works.

A hundred survivors of Hurricane

PATRICK LEARS

Andrew in 1992, treated once with EMDR by volunteer therapists in crisis clinics and shelters, reported dramatic decreases in anxiety. A man in Bellingham, Washington, shot by a robber and left for dead, got relief after five years of recurrent nightmares. A Vietnam veteran who, for 20 years, had been obsessed with memories of unloading body bags off helicopters, watched his memory fade. In its place he saw the Vietnam he'd first seen as a young soldier flying in on the plane—a garden paradise. "The war is over," he said, after one session of EMDR, "and I can tell everyone to go home."

A frightened 23-year-old woman in Mount Pleasant, New York, who stammered in the presence of men, had a single EMDR session focusing on three childhood incidents of sexual abuse involving strangers; afterward, she established her first long-term sexual relationship with a man. Another woman, suffering from an intrusive, horrifying image of her sister curled in fetal position and dying of lung cancer, felt the pain of her memory fade as the image changed from color to black and white, and she suddenly felt she could move on with her life.

Since 1987, when an unknown clinical psychology graduate student named Francine Shapiro discovered the technique while walking in a California park, more than 4,000 therapists in America, Israel and Australia have been trained in EMDR, and it has captured the attention of respected therapists from widely divergent psychological traditions. Pioneering behaviorist Joseph Wolpe says, "There are certain cases in which this is the only known potent method." Says Braulio Montalvo, one of the founders of structural family therapy, "There's something to this that's independent of the magic practitioner." And George Hartlaub, a psychoanalyst and professor at the University of Colorado Health Sciences Center, calls it "the greatest single advance in psychotherapy since I've been doing it, which is 30 years."

Are these testimonials and case studies simply evidence of the Hawthorne effect—the tendency of new techniques to get better results at first, as therapists and clients are carried along on a wave of enthusiasm and mutually reinforced hope? Is the eye movement just a gimmick? Or has Shapiro unlocked a way to help people quickly overcome lifelong traumas by affecting the brain on a neurochemical level? And if horrifying experiences can rearrange the brain's synaptic pathways in microseconds, why should we assume they cannot be healed just as instantly?

These are the questions EMDR has posed since the summer day in 1987 when Shapiro took a walk in Los Gatos park while preoccupied with old memories and disturbing thoughts. A former high school English teacher, she had developed cancer in 1979, moved to California, divorced and studied meditation, guided imagery, Ericksonian hypnosis, Neurolinguistic Programming (NLP) and anything else that seemed to hold promise. In 1987, her cancer was long past; she was 38 years old and close to getting her Ph.D.

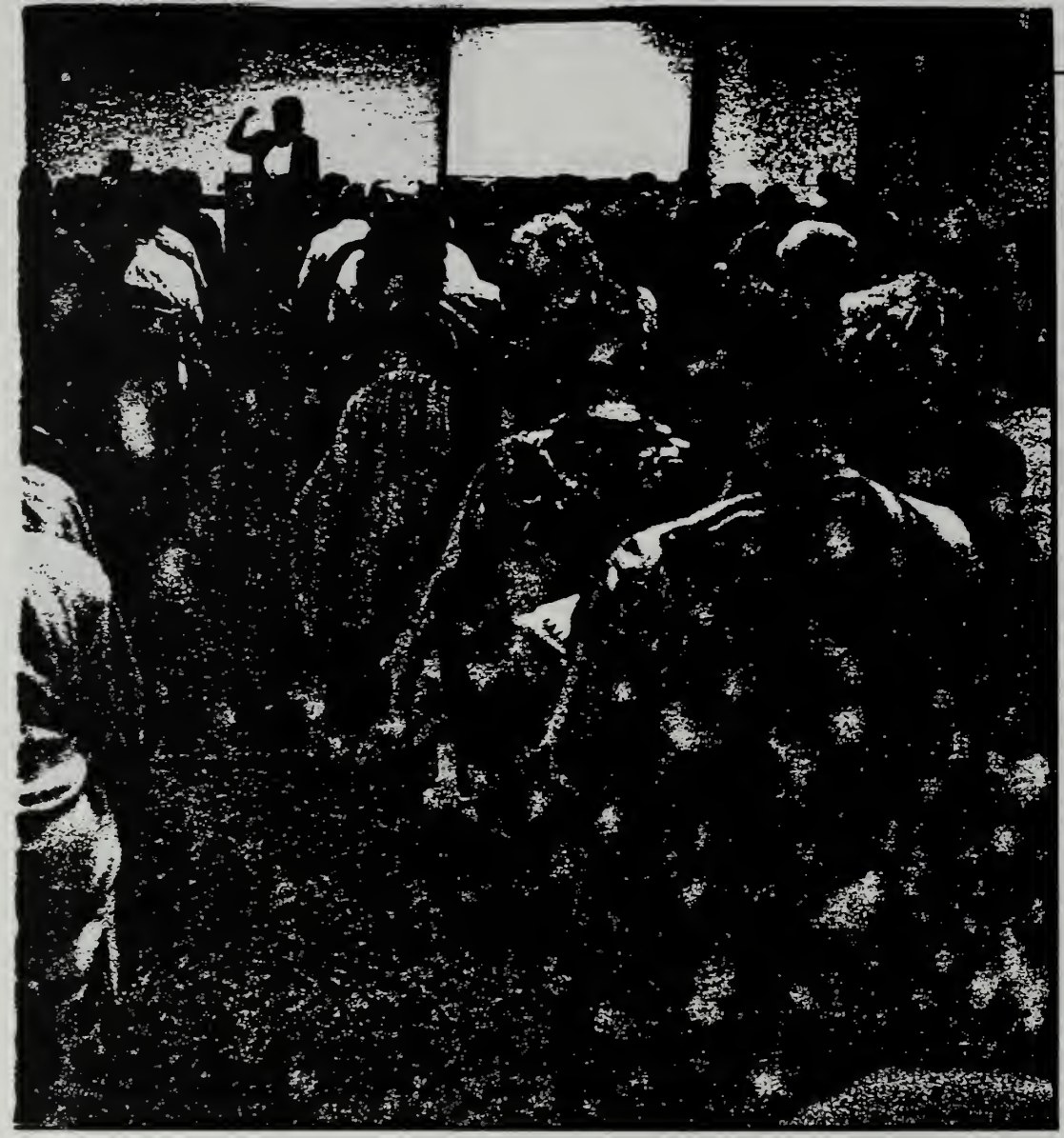
Shapiro says she no longer remembers the details of the disturbing memories that were preoccupying her that day. But they seemed to dissolve as she spontaneously moved her eyes rapidly back and forth. Amazed by her serendipitous discovery, she experimented with 70 volunteers and obtained similar results, and the next year organized a formal research study in Mendocino County, California. Her 22 subjects were survivors of rape, childhood sexual abuse and war. Their flashbacks and sleep disturbances had persisted for an average of 23 years; they had been in therapy for an average of six years; and they suffered from low self-esteem and relationship problems. Shapiro gave each of them one 60-minute EMDR session, focused on a single traumatic memory that was currently bothering them. She then asked them to tell her how distressed they felt when recalling it, and how believable they found statements expressing self-confidence and hope.

All of these subjects, Shapiro wrote in what became her doctoral thesis, said that their memories had lost most of their devastating charge, and they found positive self statements much more believable. Their gains, she said, dropped only slightly at a three-month follow-up; many sexual abuse survivors spontaneously told her that they had become more assertive and more open in their relationships. A control group that simply called up a memory without using the eye movement showed no relief at all.

It seemed almost too good to be true. (In fact, nobody has reported quite such uniformly positive results since—a testament either to Shapiro's intuitive clinical skills, or to the possibility that her clients felt subtly pressured to give her good news.) Nevertheless, armed with a published paper based on her doctoral study and some videotapes of her work, Shapiro introduced herself to the Mental Research Institute of Palo Alto (MRI) and

became a research fellow there. Still accumulating hours toward her license, she tried EMDR with more rape victims and Vietnam War vets, with an agoraphobic woman who was terrified in the presence of her husband and children, and with a child suffering from nightmares after the 1989 San Francisco earthquake. She volunteered at the local veteran's center, where one of her clients, Eric Smith, who had been haunted since the war by the remembered screams of Vietnamese women and children, had four sessions and was able to sleep through the night for the first time in 20 years.

If Shapiro had been a less driven and



GARY WAGNER

More than 4,000 therapists have already been trained in EMDR, but controversy has surrounded Shapiro's effort to restrict the use of the method to only those practitioners she has trained personally. Attendees at each of her workshops must sign a waiver promising not to train others in EMDR. Shapiro defends such restrictions by citing cases like that of a young rape victim who, after being given an EMDR session by an untrained psychologist, couldn't stop crying for 24 hours and eventually needed to be hospitalized.

Are testimonials to the effectiveness of EMDR simply evidence of the tendency of new techniques to get better results as therapists and clients are carried along on a wave of mutually reinforced hope?

more retiring woman, she might have quietly continued her work this way, exciting only mild curiosity about her intriguing and peculiar technique. But she was full of ambition, and distressed by the pain that she saw on the faces of trauma victims who appeared on television and in newspapers every day. Spreading EMDR became her mission. She wanted to see it researched and taught in universities, but also wanted it used right away. In 1989, she vigorously began to promote it among licensed therapists, targeting behaviorists because of their familiarity with brief therapy, as well as specialists in rape, incest and PTSD. She took her tapes to conferences and V.A. centers and brown-bag lunches, wrote articles for professional newsletters, and spoke to anyone who would listen. "I thought she was either a genius," says therapist Jennifer Lendl, who heard her speak at a brown-bag lunch for therapists at the Giarretto Institute in San Jose that year, "or else she was out of her mind."

At a conference in 1988, Shapiro introduced herself to Joseph Wolpe, the venerable originator of systematic desensitization, considered one of the most effective methods for post-traumatic anxiety. "She came up to me after a panel and said she had a new kind of treatment and an article she would like published," remembers Wolpe. "I was rather skeptical, but I said we would consider it. Then I tried out this method with two or three patients and it worked."

Wolpe published her article in the journal he edits, *The Journal of Behavior Therapy and Experimental Psychology*, and he and other behaviorists began to experiment with EMDR. The next year, Wolpe published his own case study, involving a woman so terrified of being raped again that she spent most of her time at home, curled protectively in a fetal position. After 15 unproductive sessions of psychodynamic therapy, she had been

given 10 sessions of EMDR; she stopped her heavy drinking, began flirting with men and enjoyed walks alone on the beach. "Post-traumatic stress disorder is an exceptionally stressful syndrome that has been extremely difficult to treat," wrote Wolpe. "The prognosis was recently dramatically improved by the introduction of eye movement desensitization... [now being] used by a substantial number of behavior therapists, with highly gratifying results. There is often a marked decrease in anxiety after one session, and practically no tendency to relapse."

Around the same time, an article of Shapiro's was published by *The Journal of Traumatic Stress Studies*. It was accepted with a mixture of skepticism and curiosity. "I thought we'd been snookered," says psychologist Steve Silver, director of the inpatient unit of the V.A. Center in Coatesville, Pennsylvania, and a member of the journal's editorial board. "I had worked in trauma for 20 years, and I had never seen people becoming desensitized to traumatic memories with the rapidity she was describing."

At the time, PTSD, especially among Vietnam veterans, was widely considered so intractable that some neurophysiologists speculated that intense trauma produced permanent changes in brain chemistry. The suicide rate among combat vets was high—more had committed suicide than had died in the war—and psychologists feared the numbers would climb even higher in the 1990s as the vets hit mid-life. Their intrusive thoughts and images from the war had not gone away, no matter what treatment therapists tried. Some had been dreaming the same nightmares and reliving the same battles for 20 years. Others found limited relief through behavioral techniques like implosion, flooding and systematic desensitization, all of which required them to repeatedly imagine old, painful scenes. But the procedures were so unpleasant that many vets refused treatment. The more years that passed and the longer the discouraged vets lived with their nightmares, flashbacks, substance abuse, work problems and family unhappiness, the more therapy success rates declined.

"By the late 1980s, things were at a snail's crawl," says Silver. "I had become a complete thief, using anything I could—gestalt, systems, implosion, flooding—anything that would show any promise, and I felt we were condemned to relative inefficiency. I was very discouraged."

At other V.A. centers across the country, Silver's colleagues felt the same. "We weren't getting very good results with intrusive thoughts, nightmares and flashbacks," says Howard Lipke, director of the inpatient PTSD unit at the North Chicago V.A. Medical Center. "The best we could do was to have clients talk about them and try to understand them."

Today, EMDR is a standard treatment at more than a dozen V.A. medical centers. "It is the single most effective thing we do," says Lipke. "Some people get complete resolution of their difficulty with a particular memory in one session."

SHAPIRO THOUGHT AT FIRST THAT she had discovered nothing more than a behavioral technique that would desensitize clients to flashbacks and nightmares. She called it "eye movement desensitization" and thought that other clinicians could pick it up, as McCann had, simply by reading her article. But as she saw more clients, she realized that more was involved than simple desensitization. Her clients often spontaneously looped back to childhood memories in a way that a psychodynamic therapist, but not a behaviorist, would expect. And as she analyzed her own work, she saw that eye movement was woven into a tight fabric of intuitive clinical skills and embedded in her own ideas about trauma's destructive impact on the brain.

Sonia Frye, for example, is a San Francisco social worker who was violently raped in 1985. Four years later, as a brief and ill-considered marriage was breaking up, she went to see Shapiro at MRI. First, Shapiro began by carefully framing Frye's traumatic memory in a way that encouraged her to notice and discriminate among her visual memories, body sensations, emotions and thoughts. Trauma survivors, Shapiro believes, are left not only with unbearable images and body sensations of horror—a pain in the throat, for example—but with chronic, self-denigrating thoughts and feelings about themselves and the world. She postulated that all of these imprints of trauma are stored together on their own neurochemical islet, so calling them all up at once increases the likelihood of finding a pathway to the traumatic material.

Shapiro asked Frye to remember the most distressing picture associated with the rape, to identify the feeling in her body (a clutching in her belly) and to identify what she called its associated "negative cognitions"—the overgeneralized thoughts that are apparently implanted along with the emotional memory of a horrifying event, statements like "I'm helpless," or "It's my fault."

Frye told Shapiro she'd thought, "If only I were married, this wouldn't be happening." She began to see a link between her suffering and her chronic thoughts and feelings of powerlessness and low self-esteem. These initial steps in the EMDR procedure gave Frye some distance from her problem and introduced the possibility that her thoughts and emotions were not "reality," but were malleable. Then Frye chose a positive thought she'd rather have: "It's past; I survived." She rated the believability of this positive belief at one on a one-to-seven scale. Then Shapiro asked her to rate the intensity of her distress, describe where in her body her feelings lay, and holding the image, thought and body sensation, she followed Shapiro's moving fingers.

"At first I thought, 'What kind of gimmick is this?'" says Frye. "Then she started moving her fingers and I was reliving it. The shakes and the sweats came back, and the tears. I could feel the shears at my throat and hear his voice saying, 'Don't cry,' in my ear."

At this point in the EMDR process, something mysterious and new occurs, something like Freudian free association at breakneck speed. Images, memories, associations, thoughts and emotions often flip rapidly through a client's mind like shuffled playing cards. Memories of childhood or related traumas emerge. Some people cry out in rage, grief or fright, reliving events. After it is over, clients aren't simply desensitized and less anxious—they have learned something; their thinking has changed.

In the course of the session, Frye says, the memory lost its power. The rigid, nonrational belief apparently installed at the time of the rape—"If only I were married, this wouldn't be happening"—faded away. After the session, she says, she could live alone without fear and recall the rape without crying—things she'd been unable to do for four years. "Now, the memory is like a book I read or a movie I saw," says Frye, who later was trained in EMDR and now uses it with her own clients. "Instead of feeling helpless, I am left with how resourceful and clever I was to say and do things that made him not hurt me."

Shapiro does not ask for the details of what passes through her clients' minds the way a psychodynamic therapist would. She obtains only enough information to choose new memories to target, rarely getting bogged down in discussing fascinating insights or in delivering interpretations of her own. She then repeats the process, targeting new images

and repeatedly asking clients to rate their levels of distress—she calls it, "getting a readout"—until all the memories have lost their disturbing charge. Once the images are exhausted, she again asks clients to rate the believability of their positive cognitions on a scale of one to seven. If all has gone as expected, an empowered, confident self-image is now believable; helpless, rigid thinking seems absurd.

At its best, this tightly focused procedure, which Shapiro describes as a power tool, seems to act like a sort of therapeutic dentist's drill or microsurgeon's laser. Many people feel as though a slate has been wiped clean and a space created where new learning can take place. Bad memories no longer make their hearts race or bring tears to their eyes. And, in an effect not often reported in psychotherapy, their visual memories actually change. A man who, at first, could only remember going down for the third time while drowning now can recall his rescue. A woman who pictured her intimidating father towering over her childhood self saw herself grown into an adult in seconds. In many of Shapiro's early cases, clients' memories lost detail, shrank or changed color, suggesting to her that something neurological was going on. As a result, Shapiro, who often speaks in the computer-influenced language of neuropsychology, renamed her technique "eye movement desensitization and *reprocessing*"; she also calls it "accelerated information processing."

Shapiro theorizes that the eye movement, and perhaps other, yet undiscovered forms of neural stimulation, allows long-delayed learning to take place. Traumatic memories, she thinks, are like unlearned lessons locked in the brain by the surges of neurochemicals that occur in times of great stress. These undigested experiences, she suggests, remain for years, tied in their own biochemical package, impervious to the lessons of countervailing, less devastating data. Somehow, the eye movement unties the package and reconnects the previously isolated neural networks to the rest of the brain. "All of the counter examples, all of the adult perspective is able to link in," she says. "What's unnecessary or degrading is discarded; what's useful can be stored."

Nobody understands the neural mechanism, if there is one, that generates such transformation. Shapiro believes that it may allow the rapid processing of survival-related data, which some neuroscientists believe happens during the rapid-eye-movement stage of sleep. Her theory owes something to Freud's belief in the shaping power of childhood trauma, something to Milton Erickson's confidence in rapid self-healing, and something to the behaviorist idea that trauma teaches maladaptive lessons that people can unlearn. What's new is a venturesome, overarching neuropsychological paradigm based on the idea that most mental disturbances can be described as blocked learning, an after-effect of trauma.

So far, Shapiro's theory remains only that—a theory. The limited controlled research so far has not proved anything unique to the eye movement. Shapiro herself has gotten similar results from tapping alternate hands on a chair rest, or broadcasting alternating tones in a clients ear. "Everybody is focusing on the eye movement because it looks interesting," says Howard Lipke, "but the best guess may be that if you help get the brain to a state where it's vigilant and alert, and at the same time you call the traumatic material to attention, that material can then be processed.

At first I thought, "What kind of gimmick is this?" Then she started moving her fingers and I was reliving it. The shakes and the sweats came back, and the tears.

SO MUCH FOR THEORIES AND TESTIMONIALS. Most new therapy movements, from behaviorism and family systems to the primal scream, firewalking and NLP, come decorated with them. All such movements generate exciting case histories, and the first clinician-converts, amazed by their successes, always beat the drum and blow the horn. At training workshops, the videotapes play over and over, and the lame eternally get up from their beds and walk again. In the workshop revival tent, the first brief miracles, however hit or miss or scientifically valid they may eventually turn out to be, shine like well-thumbed beads on a rosary.

Perhaps EMDR's dramatic successes with PTSD are just another case of this sort of suggestion: the perfect miracle for the computer age, with its technocryptic language of information processing and its talk of "readouts" and "installing positive cognitions." What about research? What about controlled studies and bar graphs and standard deviations above the mean and all the things you slept through in graduate school? How do you control for placebo, for the heightened excitement and optimism of a clinician trying something new, for differences among clients, for the varying intuitive skills of clinicians, and for the unspoken and unmeasurable rapport between the two? And how do you dissect something as seamless and subtle and multifaceted as good therapy without killing it, like a bug upon a pin? Does anyone really care why EMDR works, when people who have been unable to sleep for 20 years can now make it through the night? Sometimes, the most well-intentioned research ends up so narrowly drawn that it proves nothing so clearly as Heisberg's Uncertainty Principle: the presence of the observer changes the thing observed.

These were the questions EMDR faced in 1990, when Shapiro, who had been running what was virtually a one-woman show, began to hold weekend workshops at hotel conference centers around the country. She taught not only the eye-movement technique itself, but a package of clinical skills, including seven hands-on practice sessions. By 1993, a small but influential group of her converts, including research psychologists associated with universities and V.A. medical centers, had seen enough patients and put together enough preliminary studies to suggest that EMDR was, in fact, a watershed treatment for PTSD.

The work of Shapiro's supporters, much of it not yet published, is a step more

scientific than anecdotal case reports and a good deal less rigorous than controlled, double-blind studies. They show that in actual clinical practice, well-trained therapists achieve significantly better results with EMDR than with traditional treatments for PTSD. The most convincing is a yet-unpublished retrospective outcome study by the formerly skeptical V.A. psychologist, Steve Silver. He looked at the records of 99 veterans at the Coatesville V.A. Center, all of whom received the unit's standard treatment: a month in the hospital for intensive group and individual psychotherapy. Those who received at least five sessions of EMDR showed more than twice the therapeutic gain of those who had adjunctive biofeedback or relaxation training. The EMDR group had scores that were significantly lower than the others on questionnaires rating anger, anxiety and social isolation, says Silver, who is now one of Shapiro's strongest advocates. "She doesn't want to stand up and say we may be on the edge of a revolution in therapy," he says. "We've heard this before from every kook that's come along. But we've got a real phenomenon here, and nobody has an explanation for why this is occurring."

But Silver adds that when he first began using EMDR, he had "a hodgepodge of results." Success rates differed from clinician to clinician, and from client to client. EMDR was highly successful, but it wasn't a magic bullet. "Does everybody feel better after every session? No," says Howard Lipke. "Some people don't get much out of it at all. Some get a bit of relief the first time and a lot more in later sessions. And for some people, it brings up whole new areas they don't want to deal with."

Another slightly less rigorous study, by Roger Solomon, a psychologist with the Washington State Patrol in Olympia, Washington, showed that EMDR produced significant gains for railroad workers involved in crossing accidents. Out of 60 workers who went to Solomon's "critical incident" weekend seminar offering peer support and teaching coping skills, half were also treated with EMDR. Afterward, the EMDR group scored significantly lower on measures of anxiety and other signs of post-traumatic stress, and their distress continued to decline at a six-month follow-up.

"I have many examples of guilt-ridden, depressed railroaders with intrusive imagery of horrible phenomena," says Solomon, who has also treated policemen, Secret Service agents and truckdrivers, all of whom witnessed or participated in fatal shootings, hostage-takings and bloody accidents. "With EMDR, the images become more distant and in some cases tend to fade. People come to realize they did the best they could and it was not their fault. And it sticks. I ask people how it's going, months or years down the road and the results are stable."

These reports from clinical practice confirm the over-all experience of those Shapiro has trained. In 1992, Lipke sent questionnaires to 1,200 people who had been trained in EMDR. Out of the 400 who returned them, 73 percent said they found EMDR "more effective" than other treatments they used; only 4 percent found it less effective.

Perhaps the most informal study of all took place under disaster conditions in August 1992, after Hurricane Andrew hit southern Florida. Sixteen hundred square miles were flattened; most of the houses had not yet been rebuilt. You could drive for an hour and see only destruction. Ruth Knowles Grainger of Miami, the only therapist in Florida then trained in EMDR, quickly marshalled nine volunteer therapists to fly in from California and Ohio. They gave one or two EMDR sessions to more than 100 people in classrooms and shelters and city halls—wherever they could find a quiet corner. At the same time, Grainger assembled a research study similar to Shapiro's original thesis. Before treatment, the hurricane victims rated their distress at an average of 8 on a 1-to-10 scale. After treatment, the average distress self-rating in the hurriedly composed research project had dropped to 1.4, but the figure rose to nearly 3 after a month, and to 3.6 after three months—an increase that Grainger attributes to the continuing stress of living in devastated southern Florida. "I don't think it's a decay of the effect," she says. "We're talking about people who are still living in trailers in their driveways and in cars on the streets. We recently discovered a whole group of people in the swamps, virtually living on minnows out of the canals. The media have forgotten about us, but as much help is needed now as ever, so that people can get their anxiety down, so that they can think."

One woman whom Grainger treated several months after the hurricane had spent a half an hour trapped behind her blown-open front door, unable to reach her 8-year-old child. She came to therapy because she could not stop crying and was so distraught that she'd looked for a gun to shoot the contractor who was rebuilding her home. In therapy, she recalled the image of black, ominous clouds rolling down her street, ready to engulf her and her home. After a few passes of EMDR, the picture changed. "The clouds are still black and rolling," she said. "But they're coming to a screeching halt at the end of my street." As the EMDR continued, the clouds progressively lightened. The woman rated her distress at 0 on a 0-to-10 scale. "I still see clouds, but they're sort of pale blue and gray," she said. "Now I see the shiny part around the edge of the clouds. I see the sun rising behind them."

Perhaps EMDR is the perfect miracle for the computer age, with its technocryptic language of information processing and its talk of "readouts" and "installing positive cognitions."

IT IS A LAW OF PHYSICS THAT FOR every action there is an equal and opposite reaction; there is a law of scientific revolution that anything that advertises itself as a paradigm shift and a major advance will produce an equally vehement and opposite counter-response. EMDR is no exception. For the past three years, Shapiro, and EMDR, have run a gauntlet of attacks at conferences and in professional newsletters. They began in 1990, in the person of Corydon Hammond, an associate professor at the University of Utah School of Medicine and president of the American Society of Clinical Hypnosis (ASCH).

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"I was getting a call every week or so from somebody asking me about EMDR," says Hammond. "Two or three people were wildly excited, saying we were never going to have to use hypnosis or sodium amytol again. It sounded like the next trendy thing that was going to sweep the country with wild claims of flawless perfection. It sounded like NLP."

Hammond had read Shapiro's original article, seen a videotape, and tried out the eye-movement technique with two clients who had multiple personality disorder (MPD). His clients showed some improvement, he says, but much of it had evaporated by the next week. He wrote an article for the ASCH newsletter, cautioning practitioners against using EMDR before research proved its usefulness, and he spoke out repeatedly against it at conferences. He was concerned that EMDR would be seen as a rapid cure-all, he says, and was especially dubious about its use with people with MPD or other dissociative disorders. Such people, he says, are already adept at splitting themselves off from emotionally painful memories. EMDR, he warns, could simply encourage them to dissociate more.

"I think it may have some effectiveness, but I have serious doubts that it's going to live up to its overzealous billing. There is more to adequately resolving trauma than desensitizing fear and anxiety," says Hammond. "We also have to work through feelings of hurt, guilt and anger toward the self and others. I don't think that is adequately done with a quick-and-dirty technique."

In the letters sections of *The Behavior Therapist* and other professional journals, clinicians have questioned Shapiro's method, her scientific soundness, her training, her research, her ethics and her personal style. They were insulted by her attempts to keep EMDR out of the hands of those she hadn't personally trained, and they felt she was making outrageous claims before adequate research had been done. Skeptical critics focused not only on EMDR but on Shapiro herself—a strong, rather serious and unknown woman from California who burned with the conviction that she was on the edge of a "quantum leap in psychotherapy." Unlike Virginia Satir—an earlier female pioneer who delicately and charmingly picked her way through the thickets of this male-dominated field—Shapiro isn't disarming; she bristles when she is attacked. Some people have found her overcontrolling. She responded with long rebuttals to the newsletters, detailing her position.

In 1992, several behavioral therapists wrote a furious letter to *The Behavior Therapist* after they attended a three-hour presentation on EMDR at a conference. Shapiro, they wrote, had handed out promotional flyers for her own workshops but refused to give them enough details to teach them to use the technique on their own. "A number of disturbing clinical, research, professional and ethical issues were raised," wrote four behavior therapists and researchers from Massachusetts General Hospital. They suggested the workshop not be rescheduled unless Shapiro became willing to provide technical instruction in EMDR.

Even some of Shapiro's strongest supporters disagree with her on the issue of training. "I think it's a little absurd," says Joseph Wolpe. He believes that most well-trained behavior therapists could easily use EMDR. "She didn't train me," he says, "And that applies to quite a few other people that I know."

Shapiro says her restrictions on training were the result of reports of cases like that of a young Pennsylvania girl who had been given a little EMDR by an untrained psychologist to help her deal with the emotional aftermath of a rape. The girl seemed to relax, went home, couldn't stop crying for 24 hours and was eventually hospitalized. In another case, a California man—a client of behavioral psychologist John Marquis—tried it on himself at home while picturing a truck accident. He flashed back to a time he had nearly been struck by a train and had a panic attack that he couldn't control for half an hour.

Sandra Paulsen, a Honolulu psychologist with a cognitive behavioral practice, got a sketchy EMDR lesson from another therapist in 1991 and received no cautions about the need for training. She tried it out with a client, and before she knew what was happening, the woman, who had survived a major car wreck, was crawling across the office carpet, apparently reliving the experience of escaping from her flaming car.

Paulsen's cognitive training had not prepared her for the violent emotional catharsis. "I didn't know where to go. I tried to calm her down," she says. "I am very fervent now that people need to be trained, whatever their previous training, because EMDR is very powerful." Paulsen got herself to California for training the next weekend, ended up taking both levels of EMDR training and has since become a specialist in working with clients who have been multiply traumatized.

Shapiro at first decided that EMDR was complex and occasionally dangerous. It required hands-on practice; otherwise, it was like a power saw let loose in the hands of a medieval carpenter. In late 1990, she expanded her training to two weekends, made people who took it sign a pledge not to teach EMDR to others, stopped distributing her original article, issued cautionary updates to trainees and found specialists to act as consultants to people she had trained.

"When you go in and use what I consider the most powerful method we have to date at activating traumatic material, it's important to use really good clinical skills," warns Virginia Lewis, a clinical psychologist and senior research fellow at MRI, who chairs the EMDR Professional Issues Committee. "How stable is this person? Do they have good impulse control? Are they at risk for suicide? If I believe EMDR is appropriate at a given moment, I will use it. Otherwise, I err on the cautious side."

Shapiro says that the training is crucial for learning how to keep a client from dissociating or cutting short the intense reliving of trauma that EMDR can precipitate. The trick, Shapiro says, is to keep the client anchored in present time, while keeping the memories flowing; it's trickier than it sounds. "I didn't realize at first how much emotionally disturbing material it could open up, and how dangerous it could be for people who have suffered multiple traumas," she says.

"If you have a rape victim who goes back to an earlier molestation, you need to continue the processing, not stop them in the middle or have them dissociate," says Shapiro. "If you stop someone in the middle of remembering a suicide, they may go home and reattempt. An incest victim may go home with sensations and emotions, but no images, and that's when suicides and hospitalizations can occur."

Negative feedback also came from researchers who had not joined the rush of enthusiasm over EMDR. An unpublished comparative outcome study at Pennsylvania State University in 1992, using students who said they'd experienced trauma, failed to produce the positive results of Shapiro's original

thesis. It found essentially no difference in results between a session of EMDR and a nondirective counseling session.

And this year, Roger Pitman, a researcher associated with the V.A. and Harvard Medical School, completed one of the most closely controlled EMDR studies so far. Pitman got moderate but statistically significant improvements with Vietnam War combat veterans after EMDR sessions—and almost the same results when clients recalled their memories, tapped rhythmically on an armrest, and stared at a spot on the wall while their therapists waved their hands, EMDR style, in front of their eyes. Both sets of results, Pitman said, were about equal, and produced fewer negative side effects than flooding, a more commonly used PTSD exposure technique he'd extensively studied.

"Psychologists who work with PTSD have grasped at EMDR," says Pitman. "It's a sign of the difficulty they experience treating a fairly intractable condition. EMDR was extensively marketed before it was adequately tested and now we're finally entering the testing phase. It's very much up in the air whether its going to be found any more efficacious than any of the existing treatments for PTSD."

Other oppositional voices have arisen in other parts of the V.A medical system. In 1990, Art Blank, national director of the nation's 200 Veterans' Outreach Centers, restricted EMDR's use to his department's 50 psychologists. He considers it an unproven cognitive-behavioral technique that only psychologists are sufficiently trained to use. "This treatment has been discovered accidentally and does not have any known theoretical rationale," says Blank, a psychiatrist and Vietnam War veteran. "Even the founder says that she doesn't know what the basis for the effects are—if there are any."

NO MATTER HOW MUCH LIP SERvice is given to the importance of research, the fact remains that most new approaches are practiced without it. Medical and psychological fads often sweep the country without much knowledge of their risks—like lobotomy, routine hysterectomy, breast implants, the Dalkon Shield, aversive shocks for autistic children, and even, on a far smaller scale, Gestalt marathons and the "leaving-home" approach to families with schizophrenic members. They all seemed like good ideas at the time. Ordinary people, often desperate for healing and trusting our good intentions, continue to be unwitting research subjects in uncontrolled national experiments. For all the complaints about Shapiro's overcontrolling style, she may in fact be a little ahead of the curve on this issue. Even the limited research on EMDR is far more than what was available when Gregory Bateson first advanced the double-bind theory of schizophrenia, or when paradoxical interventions and other family systems practices were loosed upon the world.

Meanwhile, thousands of solo practitioners continue to explore new applications for EMDR—with a variety of emotional splinters and family difficulties; with survivors of sexual abuse, political torture and Central American massacres; and with depression, agoraphobia, obsessive-compulsive disorder and MPD.

So far, anecdotal reports suggest that EMDR works best with healthy adults who have suffered a single trauma—a car accident, a mugging, a hurricane. Agoraphobia and other phobias have also responded simply and well. Curt Rouanzoin, a southern California clinical psychologist, tried EMDR with a man who was terrified of driving on freeways. After a single session that brought back a memory of an embarrassing childhood incident when the family car broke down, the man came back to report he'd driven to San Diego.

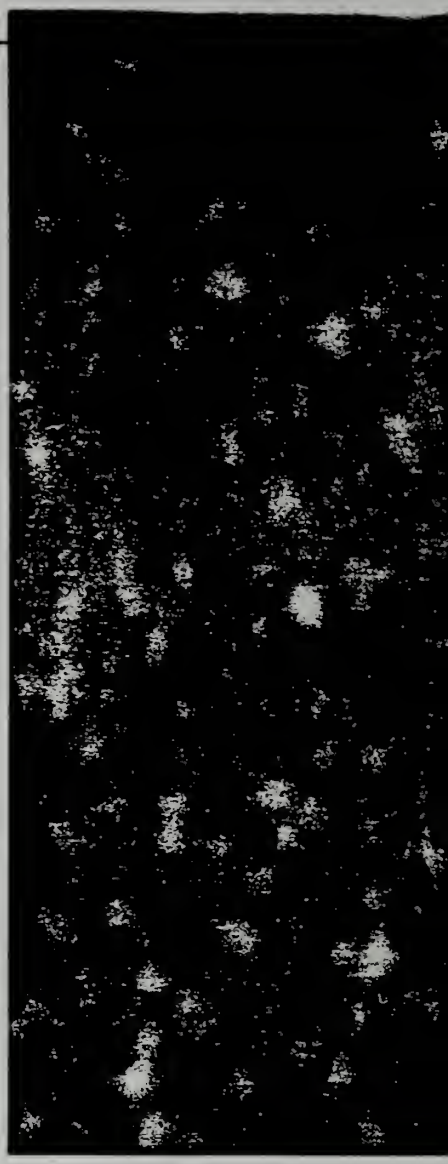
With people for whom major and minor traumas have been woven into the very fabric of their personality and memory, EMDR has turned out to be a much slower process, and sometimes a double-edged sword. California family therapist Landry Wildwind reports good results using EMDR to treat depression; she used it, along with other approaches, in what she described as "a four-year rescue operation" with a chronically depressed woman. The woman has found a good job, remarried, had a child and is close to quitting therapy, Wildwind says, but it has certainly not been a one-session cure.

In cases of obsessive-compulsive disorder, EMDR has been used with only marginal results. For reasons not understood, one long-time amphetamine user became extremely anxious and had to be hospitalized after an EMDR session. Therapists also report limited success with clients who are extremely hostile and controlling, those who don't like intense emotions or are afraid of losing psychiatric disability benefits, and those who believe that their bad feelings are somebody else's fault.

Perhaps the most delicate cases have involved incest survivors whose traumas in childhood were repeated and often brutal. EMDR can help, Shapiro says, but the work must be carefully paced. "You're not going to reprocess an entire history of incest in one to three sessions," she says. "You try to have the gentlest approach, and don't turn it into a marathon run. You have to be very careful about how much the individual can integrate, and at what pace."

Many incest victims have missed out on life skills that other children naturally acquire because they felt so isolated and powerless when they were growing up. Once they are no longer preoccupied with their troubling memories, they may discover they do not know how to date, how to say no or how to assert themselves at work or in their relationships. These skills cannot be taught by doing EMDR alone; they require practice and developing new habits. "The therapist may need to weave in assertiveness skills and suggest a dating or a job training

A hundred survivors of Hurricane Andrew in 1992, treated once with EMDR by volunteer therapists in crisis clinics and shelters, reported dramatic decreases in anxiety.



group," Shapiro says. "It's a tapestry—not only a matter of realigning threads where they're misaligned, but finding where the threads are missing altogether and weaving them in."

As time goes on, new issues may be uncovered that have little to do with incest: a fear of failure, perhaps, or a fear of success. Other interpersonal issues may emerge. "People may spontaneously find themselves being more assertive, and then bump up against people who don't want them to be," says Shapiro. "You may have to explain family issues to them, or brainstorm strategies for action."

Some incest survivors have survived devastating experiences by splitting themselves into semi-independent ego-states or full-blown multiple personalities. Unless all of the alter personalities have been identified and carefully prepared for EMDR, Shapiro says, they can emerge disconcertingly in the middle of the session. Sandra Paulsen was in the middle of an EMDR session one day when a client said to her, "Who are you, why am I here, and why are you waving your finger in my face?"

In 1992, Shapiro sent a special cautionary issue of the EMDR newsletter to everyone she'd trained, urging them to screen carefully all potential EMDR clients, in a history-taking that could take one or two sessions, for dissociative disorders and MPD. Only previously qualified specialists who had taken both basic and advanced EMDR training should attempt to use EMDR with such clients, she wrote.

THERAPISTS USING EMDR REPORT A hodgepodge of results, with effortless advances with some clients, and none with others. "I sort of expected people to be running out of my office cured," says Michael Elkin, a Boston family therapist who went to an EMDR workshop. "That hasn't happened." Others come back from the EMDR training in a nimbus of excitement that carries over to their first clients. "There's a certain energy and enthusiasm that comes through the training," says Steven Gross, a family therapist in Marin County, California. "Ninety-seven percent of the time, people were getting really dramatic experiences in the training, probably because most of us had done some inner work and were already primed. When I came out of the training, I carried a lot of that energy with me, and I enjoyed the results of it."

At first, Gross says, he saw opportunities everywhere to use EMDR, and it worked very well. But over time, as the workshop receded into the past and newer enthusiasms took its place, his results declined. Now, he tries EMDR out with most clients, but only uses it regularly with about 20 percent. It's a minor but powerful tool in an armamentarium that includes gestalt, hypnotherapy and Ericksonian hypnosis.

For therapists trained in family systems, EMDR underscores the necessity of carefully coordinating family and individual work. In one case supervised by Braulio Montalvo, one of the founders of structural family therapy, EMDR was used with a child who had lived through an earthquake and became terrified of going to school. At first, Montalvo says, the therapist investigated, in classic systems style, whether the mother was clinging and holding on to her child and somehow reinforcing and maintaining his school phobia. That turned out not to be the case, and the therapist tried EMDR. "And lo and behold nothing else was needed," says Montalvo.

But in another case Montalvo supervised, a woman worked repeatedly with EMDR on memories of abuse by her uncle in childhood, and still remained terrified. She had not told her therapist that the uncle continued to harass her mother, and she was afraid if she told anybody, her mother might be murdered. "When EMDR doesn't yield the expected relief, it's almost mandatory to come up for air and look at the contemporary family processes," concluded Montalvo. "The therapist assumed the traumatic events were back there ... but they were not back there. The abuser was terrorizing the patient's mother in the contemporary world. The client was presenting as though the offending stimuli was back there, but the refueling was occurring now.

"The technique has its power and will do something in terms of cleaning the slate as Shapiro claims. But life is complex and there's more to it than traumatic memories."

LIKE A PAIR OF HIGH-SPEED SKI boots, or space shoes made for jumping ridges on the moon, EMDR looks odd at first. It will take time for it to find a home within existing worldviews and methods. As its clinical applications are increasingly refined, it will face a new set of questions: When does it work best? For what kind of clients? And for what kind of therapists?

In the right hands, with the right clients, at the right moment, EMDR clearly can be a powerful tool. But the individual therapist is an important variable too: technique and technician are as intimately joined as Siamese twins. In a field full of people guided by the intuitive, the most rigorous scientific research will not force the acceptance of a practice that seems mechanical or fails to speak to the relationship needs that motivate people to become therapists in the first place. For the moment, EMDR will only take root among people comfortable with the uncertainty of its still-developing theory, its robotic neuropsychological language, and the odd, sometimes tiring mechanics of waving one's fingers repeatedly in client's faces.

GARY WAGNER

If it demonstrates its usefulness, EMDR could be a method that will catch on in a field increasingly pressured to provide quick results. At the same time, it is being introduced into a professional community that has grown jaded to approaches that make overarching claims. "More and more people realize that no one approach has all the answers," says Olga Silverstein, cofounder of the Women's Project in Family Therapy and a longtime observer of the field. "Today, we're better able to tell the difference between an interesting new idea and a total solution."

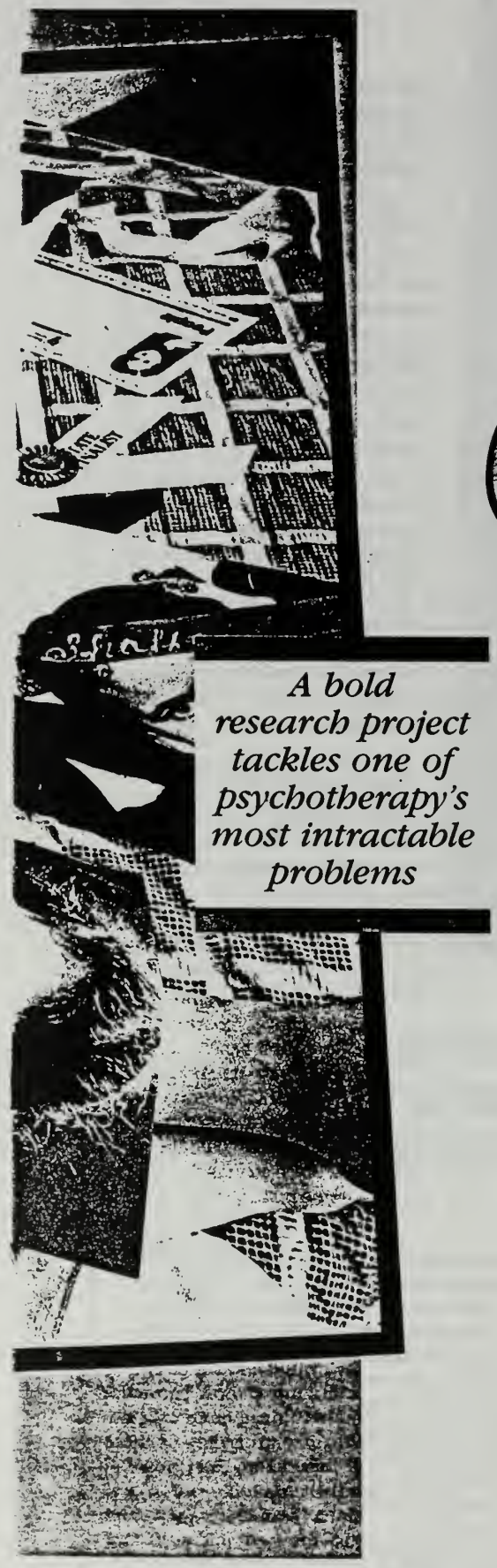
There is a law of scientific revolution that anything that advertises itself as a paradigm shift will produce an equally vehement and opposite counterresponse. EMDR is no exception.

"Stylistically, it isn't my stuff yet," says Michael Elkin. "I don't have a clue how it works; I think there's really something there, but I don't know how to integrate it yet with what I already know." Other therapists who have already found EMDR effective have painfully had to revise their previous thinking. "For some people, this is clearly more effective than a completely traditional, nondirective approach," says Philip Manfield, an experienced psychologist who used to work primarily within the object relations tradition. EMDR, he found, can save clients weeks or months of depression as they come to terms with the painful truths of their childhood. But he is still not sure if it goes as deep as his long-term work, which few people can afford these days. "It's upsetting," says Manfield, who sometimes finds himself in conflict with former colleagues. "I'm having to integrate this new material, and it's hard to wear more than one hat."

Such expansion of intellectual boundaries—and the integration of formerly suspect psychological perspectives—may be one of the side-effects of the spread of EMDR. Psychoanalysts are integrating a more aggressive cognitive style into their work; behaviorists have discovered the labyrinth of childhood; and family therapists have found a way to work effectively with individual childhood issues without getting bogged down.

But whatever EMDR's virtues and limitations finally prove to be, some clinicians just aren't going to like doing it, and others will. And while the scientific debate continues, the primary experiments will continue to take place daily in the individual therapist's office, and in the wider laboratory of their clients' lives. ■

Katy Butler is a writer whose work has appeared in The New Yorker, The Washington Post *and* Mother Jones. *Address: 116 Buena Vista Ave., Mill Valley, CA 94941.*



RESEARCHING
PTSD

GOING FOR THE CURE

A bold research project tackles one of psychotherapy's most intractable problems

VOLTAIRE ONCE WROTE THAT HISTORY WAS "LITTLE ELSE than a picture of human crimes and misfortunes," but not until our own era of mass communication did it become practically impossible to escape constant bombardment by bad news. Wars, natural disasters, industrial catastrophes, highway carnage, crime, terrorism, sexual abuse, rape, domestic violence—all make trauma a horrible and daily leitmotif of the 20th century. The saving grace to this bleak picture, however, is that a culture steeped not only in the ever-present images of trauma but also in the concepts of mental health is becoming more aware that even during the course of ordinarily uncatastrophic lives, things will happen that have the power to shock and wound perfectly sane and well-adjusted people to their very core.

An estimated one-half to three-quarters of the general population in the United States has been exposed to an event that's severe enough to result in

BY MARY SYKES WYLIE

diagnosable Post-Traumatic Stress Disorder (PTSD). How many traumatized people actually develop PTSD is another question, but the number is probably high. According to various studies, 47 percent of rape victims suffer from PTSD three months after their assault, for example, while 25 percent of those who lost a relative to an accident or violence are diagnosed with it, along with 31 percent of Vietnam War veterans at some point in their lives and up to half the victims of natural or manmade disasters. In short, as many as 25 percent of the people exposed to the traumatic events that are becoming endemic to modern life can be expected to develop full-blown PTSD as a consequence. These people—our neighbors, our friends, our families, ourselves—are thus vulnerable not only to the horrifying flashbacks, nightmares, irrational fears, sudden angers and emotional numbness that officially define PTSD, but to the less dramatic anxieties, depressions, substance abuse, phobias and personality disorders that may follow in its trail.

As many as 25 percent of the people exposed to the traumatic events that are becoming endemic to modern life can be expected to develop full-blown PTSD as a consequence.

Yet while the epidemiology of PTSD has been exhaustively documented, the remedies are not remotely so obvious. Even as treatment methods for PTSD and claims for their effectiveness proliferate, hard outcome research—randomized, controlled studies that meet the gold standard set by mainstream academic psychologists—is sparse. In 1992, National Institute of Mental Health researcher Susan Solomon discovered that of 255 English-language articles describing "effective treatments" for PTSD written since 1967, only 11 were randomized, controlled studies—the rest were mainly anecdotal. And of the 11, 5 were pharmacological studies showing little or no improvement in PTSD. Of the remaining 6 studies—of behavioral and cognitive techniques—the most improvement came when a combination of both modalities was used in a study of 66 rape victims; nearly 70 percent no longer showed symptoms of PTSD after three months. Since then, two or three other controlled studies of cognitive-behavioral therapy with rape victims have shown very good results. There are also several controlled studies of PTSD treatment by Eye Movement Desensitization and Reprocessing (EMDR), a fairly new approach that is so controversial that the validity of research done on it is still vigorously debated. But with these meager exceptions, a therapist looking for solid research evidence for treatments routinely used for PTSD won't find much on which to hang an intervention.

Of course, if therapists had to wait for empirical validation for their favorite model or the ad hoc mix-and-match methods they customarily use before treating clients, their ranks would probably shrink to a tiny remnant of cognitive-behaviorists seeing mainly phobics—leaving the rest of the field almost entirely to medication-prescribing psychiatrists, who wouldn't be doing much actual psychotherapy either. But most therapists don't wait for the latest outcome study, with its tables, graphs, scales, subscales, inventories and t-scores. Faced with a desperate client who isn't improving, they are more likely to plunge ahead in an old-fashioned spirit of what-the-hell empiricism, and try almost anything in any combination, from the old standards of the psychology texts to the latest workshop sensation.

Academic researchers are appalled by what looks to them like treatment promiscuity and by clinicians who behave like impressionable groupies, serially infatuated by a long line of performance artists, magicians and mountebanks. Like weary and beleaguered defenders of reason in a world overrun by superstition, research psychologists argue that psychotherapy can have little standing as a reputable science of healing until its methods have been empirically demonstrated to work. These critics of the clinical vox populi argue that the alleged "miracle cures" popping up in the field like dandelions after a spring rain are merely artifacts, piggybacking on the unmiraculous facts of therapy in general. Researchers point out, for example, that clients tend to improve no matter what the clinical model; the positive effects of their own hopes and expectations of improvement, the novelty of the new technique, the therapist's undivided attention, empathy, suggestion and personal *talent* are often indistinguishable from the specific impact of a particular method. Without the rigors of a scientific method that controls for all these "confounding" issues, how is it possible to know whether something new and different really *is* something new and different, or just the same old stuff tarted up in new duds?

The lack of academy-approved, hard

validation for most therapy methods has not stopped thousands of clinicians from using whatever methods they think will help their clients, with most generally feeling at the end of the day that they have probably helped somebody, somehow. But PTSD seems different. Faced with clients who have experienced, or committed, the worst enormities life has to inflict, many therapists lose heart and the confidence that they have much to offer. Listening to the harrowing stories of their traumatized clients, clinicians themselves can succumb to the pernicious contagion of PTSD symptoms—the intrusive images, nightmares, exaggerated startle reflex, irritability, sense of helplessness and confusion. Furthermore, people whose lives have been shattered by war, child abuse, political imprisonment and torture—their symptoms often compounded by substance abuse, failed relationships, job instability—are among the most compelling and demanding clients therapists ever meet. "Working with vets, I am confronted daily by suffering of an intensity that no person should ever have to experience," says Jean Steinberg, a psychologist with the PTSD unit of the Department of Veterans Affairs in Salisbury, North Carolina. "It can take months and months of work before you see an impact on even one chronic nightmare."

Severely traumatized clients challenge not only the effectiveness of standard therapies but their very relevance—as if the ordinary stuff of clinical interventions were somehow trivial in the face of suffering beyond the pale of any neat diagnostic category. Kate Sorensen, director of Trauma Relief Services, a private agency in Flagstaff, Arizona, recalls that several years ago, she had nearly burnt out on therapy after working for two years on a Navajo reservation with traumatized children and adolescents. "There were just too many heart-breaking stories," says Sorensen, "and although I sometimes felt helpful, I practically never felt I could do enough for [kids] in such desperate need."

Sorensen remembers one incident in particular—a 13-year-old boy referred by the local school for fighting and doing poorly in school, whose father had shot himself in his truck three years before while his son sat next to him in the passenger seat. Sorensen says that she knew this was at the base of his problems, but that "he didn't really want to talk about it, and I didn't want to poke around when I had no confidence in what I was doing. I'd been taught the usual things—counseling, reflective listening, some cognitive-behavioral techniques—but I really didn't have much sense of how to help somebody who obviously had suffered an enormous wound. What was I going to say to this boy, 'When your dad blew his brains out as he sat next to you, how did that make you feel?'"

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YET DESPITE THE OFFICIAL PESsimism about recovery from chronic PTSD and the void in the literature where effective treatment outcome studies should be, some lucky therapists approach the work with the confidence and enthusiasm of people who know they are making a difference, because their clients *are* recovering. During the early '90s, while researching a book on compassion fatigue—the harder, meaner form of burnout to which trauma therapists are prone—Charles Figley, director of the Florida State University Psychosocial Stress Research Program in Tallahassee, Florida, began to meet many therapists who seemed to be immune to the condition. Talking at meetings around the country about the price that PTSD extracts from therapists as well as clients, he discovered clinicians who not only worked regularly with trauma survivors and managed to avoid burnout in the process, but actually found the experience rejuvenating! "I was finding that some therapists, in spite of the fact that they saw a large number of traumatized clients, experienced compassion exhilaration because they were curing people through extraordinary treatment methods." True, the voices of these cockeyed optimists were not coming from official channels—not from de jure representatives from Ph.D. psychology programs, academic research institutions, large mental-health facilities (though individual therapists in them might be heard)—nor from strict practitioners of only standard methods.

Instead, glowing reports that often amounted to the professional equivalent of born-again experiences were coming from a kind of therapy underground as distinct from the orthodox centers of psychology as the secret, pagan folk religions of the Middle Ages were from the established Roman Catholic hierarchy. In the course of his professional sojourns, Figley would talk to colleagues who reported hearing about methods that had amazing results. Word-of-mouth reports came from people who said they had seen something in a tape or at a workshop, had tried it and their clients had made wonderful progress; now, five years later, they were still using the technique and new PTSD clients were also making wonderful progress.

Indeed, describing their results, these everyday pioneers even dared openly to use the taboo "C" word—cure—a brazen and immodest claim in the genteel professional establishment. Further, they were doing their cures in record time; instead of the 20 to 300 or more hours of therapy Figley cites as typical for PTSD, it would take them 2, or 3 or 4 hours. And instead of a painful, long, drawn-out process of reliving the trauma, which therapist and client found harrowing (flooding, for example, a therapeutic form of intense exposure to the traumatic material, can elicit severe depression, suicidal thoughts, alcoholic relapse and panic disorders), what Figley was hearing about seemed much less agonizing for both helper and helped.

Faced with clients who have experienced, or committed, the worst enormities life has to inflict, many therapists lose heart and the confidence that they have much to offer.

By this time, around late 1992, Figley had grown deeply tired of the professional jeremiads about PTSD—how prevalent, how damaging, how incurable. There were, and still are, no studies, says Figley, showing that any standard method leads to complete remission of symptoms. "We have failed miserably to treat PTSD," he says. "In most instances, people with chronic PTSD are just giving up, learning to organize their lives around their disability. And the blame for this has to be laid at the feet of those of us who call ourselves experts. We've done a crappy job."

It is a hard assessment, but nobody is in a better position, or less afraid, to make it than Figley, who helped invent the field of traumatology. A Vietnam veteran himself, Figley became aware of a complex and disabling malaise in some of his wartime peers in 1971, when he spent three nights preceding a peace demonstration in Washington, D.C., with a crowd of Vietnam Vets Against the War. A few years later, Figley, then a professor at Purdue, met Shad Meshad, also a Vietnam vet, who was "working the streets," doing impromptu therapy and rap sessions with stressed-out vets. The two fought and won a campaign for federal legislation mandating psychological treatment for Vietnam veterans. In

UNDER THE MICROSCOPE

BY MARY SYKES WYLIE

1978, the book Figley edited, *Stress Disorders among Vietnam Veterans*, was the first to name and describe the condition he had seen seven years earlier, which would evolve into the formal diagnosis of Post-Traumatic Stress Disorder, included, for the first time, in the 1980 *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

Figley's career seems dedicated as much to publicizing PTSD as researching it, and he seems to have a genius for getting people's attention, if not endearing himself to the authorities. Not that he cared then or does now. "I've reached a point where I don't give a damn what other people think," he says. Besides writing articles and editing numerous books on psychosocial stress, Figley founded the International Society of Traumatic Stress Studies; the *Journal of Traumatic Stress*, the first online computer traumatic studies journal; and the Green Cross—a fledgling international, Internet-connected organization that mobilizes and dispatches therapists to disaster areas around the world. "Working with Charles is like riding on a roller coaster—you never know where he's going next," says Gail Davies, director of the Psychosocial Stress Clinic at Florida State. "About the time you think you've gotten what he's talking about, he's onto something else. His mind just never stops, although it's sometimes hard to understand where it's going."

Typically impatient, Figley decided the normal snail's pace of academic research on PTSD was not acceptable: "What we had been doing wasn't working, and I thought we had to take a different tack, move beyond the university research setting and into the community."

To say Figley was open to the stories he was hearing from the psychotherapy trenches about therapists not only helping, but *curing* PTSD clients, understates the case. "I wanted to find out what they did, how they did it, how they knew that what they were doing worked. I wanted to catch them being successful, maybe develop out of their communal experience a new theory, a new paradigm. I didn't care what they did or who invented it, I just wanted to know what it was. I wanted to figure out how we could stop the suffering."

Figley also felt that psychotherapy research is past due for an overhaul. "The entire method by which we sanction clinical procedures is flawed beyond repair," he says, because as it now stands, academic re- *Continued on page 29*

Scrutinizing some promising approaches to treating PTSD

Eye Movement Desentisization and Reprocessing (EMDR)

The best-known of the four methods Figley and Carbonell studied is probably Eye Movement Desensitization and Reprocessing (EMDR). Developed by psychologist Francine Shapiro, it makes use of right-left visual, kinesthetic or auditory stimulation while the client mentally focuses on traumatic experiences. Most typically, the client thinks about the traumatic memory and the negative beliefs associated with it (i.e, "It was my fault that I got raped.") while visually tracking the rapid back-and-forth movements the therapist makes with two fingers or a wand before his or her face. Alternately, physical taps or auditory tones may be used. During this "desensitization" phase, according to the practice, the client's subjective feelings of pain, anguish and panic decline or disappear, while new insights about the original traumatic event or its meaning emerge. At this point, the EMDR therapist takes the client through further "sets" of back-and-forth stimulation—the "installation" phase—during which the client integrates the trauma experience into his or her life and experiences a kind of personal psychic transformation as well.

According to Shapiro, the effectiveness of EMDR relies on the brain's enormous resources for physiological adaptation to and recovery from disturbing events. "We think [about the incident], talk about it, dream about it and eventually it doesn't bother us anymore," she says. "We say it has arrived at an adaptive resolution; we incorporate what is useful to us, learn from it and store it with the appropriate emotional affect." In some cases, however, a severe trauma (or one that the subject finds severe) bombards and overwhelms the survivor's information-processing systems—emotional, cognitive, neurophysiological—leaving him or her unable to absorb the event and "get over" it. "What the person heard, thought, felt, saw is locked up in the nervous system and can't link up with more adaptive information," says Shapiro. Learning doesn't take place, the information is stored in state-dependent form [in the same frame of mind and body as when the trauma occurred] and is triggered by environmental stimuli. That results in nightmares, flashbacks and all the other symptoms of PTSD."

In a chapter for a forthcoming book, Shapiro describes the case of Theresa, a single mother whose 12-year-old son and only child was killed by a train about a year before she went in to see psychiatrist Steven Lazrove, a therapist who uses EMDR at the Yale Psychiatric Institute in New Haven, Connecticut. After getting her story the week before, Lazrove had her read it aloud during the first treatment session, and once determining how disturbing it was for her on a scale of 1 to 10 ("a 10," she said), asked her to describe the worst part of the story for her—what she saw in her mind's eye, how it made her feel and what it made her think of herself, and then, what she would rather feel. She said she could not get out of her mind the thought of "the body parts." She added that the emotion was a terrible pain in her chest, a sense that "my heart was stolen from me," and that she believed that it was all somehow her fault. "I feel guilt. He was my responsibility." After eliciting from her a more "positive cognition"—that what happened was an accident, and *not* her fault—Lazrove asked her to concentrate on the most disturbing image while he began doing sets of eye movements.

Gradually, during the course of about 12 sets, lasting about 30 minutes, the woman no longer saw the gory scene of the accident or the funeral, but sad-

ly remembered her first Thanksgiving without her son. She then visualized holding her son, not wanting to let him go. A few more sets, and she had moved to seeing herself walking alone, laughing with her fiancé or watching a new fence being built along the railroad track. By the end of this first session—23 sets of eye movements and 1 hour and 11 minutes after it began—Theresa has imagined talking to her son, who tells her she must try to be happy without him. When Lazrove asked how much distress the original scene causes her, she answers "zero . . . I feel relieved. I feel more comfortable, like a weight is lifted off me."

By the end of this first session—23 sets of eye movements and 1 hour and 11 minutes after it began—Theresa has imagined talking to her son, who tells her she must try to be happy without him.

During two more sessions of EMDR, Theresa came to feel that it had neither been her fault, nor her son's fault nor the fault of the other little boy who had been with him, who escaped. By the time of a follow-up visit 15 months later, Theresa had resumed work. She was sleeping well and no longer having obsessive memories about the accident. She had also given birth to a new baby.

Traumatic Incident Reduction (TIR)

According to Frank Gerbode, founder and director of the Institute for Research in Metapsychology in Menlo Park, California, Traumatic Incident Reduction (TIR), which among many other influences has roots in Sigmund Freud's theory of unconscious repression (without the interpretation and analysis) and Carl Rogers's client-centered approach (without the lack of direction), is not really a therapy at all. "We don't do therapy. I don't regard TIR as a therapeutic approach, nor is it embedded in a therapeutic context," says Gerbode. "It is an educational model for helping people achieve personal growth."

Unlike EMDR, with its echoes of neurophysiological concepts, TIR sounds almost old-fashioned in its apparent focus on mind and mentalistic imagery. Trauma is an experience so intense and overwhelming, says Gerbode, that victims can't fully confront it or allow themselves to experience it totally. They form an "intention" during the chaos of the trauma, in effect an unconscious decision, to resist it, to fight it, to protest it, to refuse awareness of it, to escape it, to quash it—an intention they retain, even when the danger is long past, even in circumstances that have nothing to do with the original event. The Vietnam vet who avoids going downtown because he cannot tolerate crowds (even though he "knows" he is not in Saigon), the raped woman who is terrified of all men (even though she "knows" that all men are not rapists) are still adhering to old intentions, blindly made in the heat of terror. TIR, says Gerbode, takes the traumatized person back to the original event in a way that allows him or her to examine the circumstances and conditions—many forgotten—in which the old life-saving intention was made; examine it in light of new knowledge and let it go.

TIR purportedly not only relieves clients (or "viewers," as they are called) of the symptoms and emotional detritus of PTSD but enables them to achieve new insights and realizations about the original incident that can transform their lives. TIR viewers focus on, or "view," only one trauma at a time. If resolution is not achieved, it means that the target is only a kind of screen or reminder of an earlier traumatic experience, which will then become the new focus of attention. Then on back, individual trauma by trauma, until the "primary" event is reached. TIR's directed focus on one thing at a time, however nasty, makes it less likely to mushroom into multitudes of deeply upsetting or retraumatizing new issues its proponents say. Further, it is a hard rule of TIR that no client ever leaves a session without some sort of resolution—an "end point," characterized by astonishment, obvious relief, the expression of some major insight or realization, spontaneous laughter or the giddiness that inevitably marks the abrupt dissipation of the trauma's impact, like an ancient fortress suddenly crumbling to powder. "Nobody leaves the session until the issue is resolved and it's a done deal," says Robert H. Moore, a TIR therapist in Clearwater, Florida.

Embedded in a rather cerebral philosophy called metapsychology, the actual practice of TIR itself seems deceptively simple; at least as it is followed on paper, almost anybody *could* do it. Says Gerbode, "All the facilitator does is give instructions that allow the viewer to generate his or her own insights." The facilitator's instructions are formulaic, specific, neutral: "When did the [traumatic] incident happen?" begins the facilitator at the start of the session. "Close your eyes. Move to the start of the incident [without talking] and tell me when you are there." "What are you aware of?" "Move through to the end of the incident [without talking]." Then, "Tell me what happened." "How does the incident seem to you now?" and so on. During

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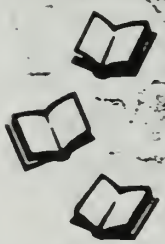
ILLUSTRATIONS BY JEFFREY L. DEVER

numerous repetitions of this same formula of thinking about the episode and then describing it—5 to 10 to 20 times or more, each taking only a very few minutes—the facilitator neither validates nor questions the viewer, nor offers comments or encouragement. The details focused upon and the reactions they elicit, however, change with each repitition, as the viewer rediscovers forgotten details, rethinks others and acquires a different perspective on the impact and meaning of the whole event.

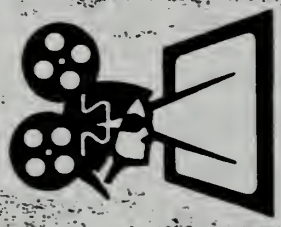
In one case, for example, a depressed 44-year-old salesman, a chronic underachiever with lifelong feelings of failure and inadequacy, reported that much of his unhappiness stemmed from his relationship with his aggressive, demanding and authoritarian father. The key incident he remembered was the afternoon when he was a very young boy and his father had forced him to practice catching a hardball over and over, scaring him, hitting him with the ball, angrily berating and humiliating him when he missed. During his first telling, the man is obviously reliving and reexperiencing the fear and pain of the original incident, convinced that his life has been ruined by it. With each telling, however, something new comes to light. At one telling, about the 10th or 12th, he admits that "distasteful as [the experience] was, it really taught me to catch a ball." Later he remembers how much he really had wanted to learn to play ball—and that he had become a pretty good ballplayer, which wouldn't have happened without his father. Still later, at another pass-through, he says he knows his father was not a well man. "I know I was abused . . . but maybe he's not the villain or ogre I painted him; maybe I've been looking for a scapegoat, someone to blame my own inadequacies on."



Eventually, he says softly that his father didn't have much "tact or diplomacy," but "he did what a father should have done, made me face my fear, conquer it and benefit. . . . I wanted to do that, but didn't want to go through the process. He made me do it, so I owe him." Throughout these later tellings, his entire aspect has changed. No more the long-faced, self-pitying man obsessing about his miserable childhood, he now looks brighter, his face open and smiling; he laughs, shakes his head. "Jesus, that's weird. I'm actually grateful, but I didn't start out feeling that way. What I thought was a negative experience turns out to be positive. Can you explain that?"

Visual Kinesthetic Dissociation (VKD)

Visual Kinesthetic Dissociation (VKD), a method based primarily on Neuro-Linguistic Programming (NLP), begins with a version of the standard premise among PTSD therapists that, for many traumatized clients, time stands still. Stuck in the terrible "present" of the trauma's worst moment, they are continually, subjectively reliving it, thus unable to grasp that it has already happened and is over. In the language of NLP, they are only too "associated" with it, feeling all the original sensations as if from inside the event rather than observing it from an outside perspective—the way most people experience painful past events that no longer disturb them.



VKD practitioners take clients through a step by step program of purposeful dissociation *from the trauma—gaining them the ability to observe it a distance instead of being subjectively overwhelmed by it.*

VKD practitioners take clients through a step-by-step program of purposeful *dissociation* from the trauma—gaining them the ability to observe it at a distance instead of being subjectively overwhelmed by it. When they are able to separate themselves from the event in time and space, they have the presence of mind, so to speak, to allow them to actually take in the "information" that the trauma is no longer happening—it is past, it is over. The new information that VKD (or TIR or EMDR) helps clients take from the event—missed during the first terrible go-round of the actual trauma—seems to be the missing link, the key that is necessary both to put the incident in its place and to enable the traumatized person to extract from the stony ground of pain and suffering a renewed sense of personal wholeness and self-respect.

In a VKD session, the therapist first creates a rapport with the client—taking history, finding out about his or her life before and after the critical watershed of the trauma. The therapist asks the client what he or she lost as a result of the trauma, what the client would like to have back and what he or she possibly gains by keeping the trauma alive, while monitoring how the client reacts physically when thinking or talking about it. At that point, the client is instructed to establish a "here and now" anchor, by squeezing the therapist's hand or chair, while being told something to the effect that "this will remind you that you are here, safely, with me in this room."

The therapist then asks the client to "double dissociate," by imagining watching him- or herself looking at a movie of the traumatic scene, allowing as much distance as is needed to keep from being once again captured by the event. Finally, the client is asked to run the movie of the traumatic event from the very end back to the beginning very fast. After running the "movie," the client is asked "What do you know now about that time that you didn't know then?" Frequently, this question evokes in the trauma survivor the astonishing piece of "new information" that he or she actually survived! This knowledge the client is then instructed to "take back" to the younger self who underwent the trauma, along with any other reassurance, comfort and encouragement that might help—what he or she did to survive, what has happened since. The client can imagine actually appearing in the movie, hugging and telling the younger person that this event will never happen again. Then, the clinician can ask the client to imagine bringing that former self away from the trauma experience down into the room, folding that small self into his or her heart. If all has gone well, by now the VKD

practitioner will have good indications of a shift in the client—perhaps the client sighs peacefully, appears relieved and much calmer. Finally, the practitioner tests the client by asking him or her to think of whatever events previously elicited the PTSD response, watching the client's nonverbal reaction and listening to his or her verbal report.

Almost immediately, this client, who had been so terrified of water she could not go out in the rain or fill a bathtub, said, "The fear is gone!" and went frolicking exhuberantly around the swimming pool Callahan had behind his home office.

Technically, all of this somewhat complicated visualization process could be done without the client uttering a word. That VKD demands so little verbalization is an advantage, says Dade County, Florida, police sergeant and NLP practitioner William Garrison. It is particularly suitable for working with police officers, who sometimes need to keep the details of certain crimes confidential, or a rape victim not ready to discuss the details of the attack with a strange man. The method is fast—10 to 30 minutes is not unusual—and extremely portable. Garrison's "office" can be in the backseat of a police cruiser, on a street corner, at a hospital, in a restaurant. After Hurricane Andrew, he worked with survivors in the parking lot of the police station. And, according to Garrison, VKD appeals to pragmatic police and fire officers who want "observable, testable change" that doesn't reek of therapy. After VKD, he says, "they know something is different, something has changed; they feel more in control, more empowered, as if the world were getting back to normal."

Thought Field Therapy (TFT)

By far the most unusual method and most resistant to ordinary explanation is Thought Field Therapy (TFT), which originated in one of those serendipitous moments in the life of its inventor. In 1980, cognitive psychologist Roger Callahan had tried everything in his repertoire—cognitive-behavioral approaches, systematic desensitization, hypnosis—to help a woman with a lifelong, severe and apparently intractable water phobia, with little effect. More desperate than hopeful, he decided to try a personal variation on applied kinesiology (AK), a holistic, mind-body healing method he had been studying, based on the theory in Chinese medicine that energy flows along meridians and can be balanced and released by contact on acupressure points. Finding that the woman's stomach energy system was out of balance, according to the AK diagnostic system, Callahan gently tapped an acupressure point under her eye that corresponds to the stomach and asked her to think about water. Almost immediately, this client, who had been so terrified of water she could not go out in the rain or fill a bathtub, said, "The fear is gone!" and went frolicking exuberantly around the swimming pool Callahan had behind his home office. Her phobia was not only diminished, it had completely evaporated, an apparent cure that remains to this day.

Extrapolating from this and other similar cases, Callahan postulated a connection between what he calls "perturbations" in the "thought field"—any negative emotional condition or disturbance, including phobias, depression, addictive urges, anxiety, traumatic stress, guilt and so forth—and disruptions in the body's energy system. Over the years, he has expanded and elaborated his system to include a number of brief treatments, or "algorithms"—step-by-step procedures or sequences—of body taps geared to particular conditions, which clients can perform on themselves. In addition to the various algorithms, Callahan has developed a diagnostic methodology based in part on an AK-muscle testing procedure (which identifies disruptions in the body's energy field) and a patented, proprietary "voice technology"—an electronic device that converts the sound of the voice to a visual display, making it possible to diagnose where the client's "energy blocks" are by phone.

Having determined a trauma diagnosis, for example, the therapist using the trauma algorithm asks the client to think about the event and estimate an SUD (Subjective Units of Distress) rating for it. The client is then instructed to tap firmly five times with two fingers at the beginning of the eyebrow, under the eye, under one arm and just below the collarbone, at which time a second SUD rating is taken. The same process is repeated until the client lowers the SUD rating to one or two. If, as is usually the case, the client experiences little or no relief, it is because of something called "psychological reversal," a kind of systemic mind-body negativity or block that Callahan attributes "possibly to an electrical polarity reversal." To clear this up, the client is asked to tap on the outside edge of the hand, while saying three times, "I fully accept myself even though I have this problem." The treatment for trauma now resumes with what is called the Nine-Gamut Treatment, during which the client taps the spot between the knuckle of the little and ring fingers, while going through nine steps, about five taps per step: open eyes; close eyes; open eyes and look down and to the left; look down and to the right; circle eyes in one direction; then the other; hum a few bars of any tune; count to five and hum a few bars again. Then, the original set of taps is repeated.

Although clients must mentally "tune into" the problems being treated, they are not required to talk about them at all. "TFT bypasses cognition," says Callahan, and just about everything else normally associated with therapy. Rapport, empathy, attitude, motivation, mutual understanding, internal struggle, insights, hope, expectation of success are all irrelevant. "We don't get our fair share of placebo cures," says Callahan, who suggests that very few clients actually believe the method is going to work, and often don't believe it even after it has successfully removed their problems. Doubting that something so seemingly preposterous could work, people report dramatic changes, but often deny that TFT had anything to do with it—claiming that the method "distracted" them from their complaints, for example, or that they simply can't think about the problem anymore.

TFT confounds all standard assumptions about the definition and practice of psychotherapy and the nature of emotional disturbance. Clients who have had successful experiences with it feel less transformed than simply, but definitively, relieved of their pain. One Vietnam vet, for example, haunted by a wartime memory of having to shoot a child who was coming at him with a hand grenade, never able even to talk about the event without falling apart, recounts the incident calmly and without distress after two 5- or 10-minute TFT sessions. "It's just like I'm watching a movie," he says quietly. "I now realize it was him or me; I had to do it." Another vet, unable to shake a nightmare that recurred two or three times a night for 30 years, was treated with TFT by psychologist Jean Steinberg at the Veterans Affairs medical center in Salisbury, North Carolina. At the third use of the trauma algorithm, the client suddenly jerked and said he felt a strong, shock-like tingling up and down his arm. The relived battle scene that had destroyed his sleep for three decades began to get fuzzier in his mind, then fell into shadow and disappeared entirely. Since Steinberg first began using the method six months ago, she says it has been successful with two-dozen men, and that results have so far remained in effect, three to six months after treatment.

Several years ago, Pennsylvania psychologist Fred Gallo first used TFT, which he had just learned, on a 32-year-old client who had never recovered from being raped when she was 13; even after several years of therapy with him, she still couldn't talk about it. Gallo tentatively suggested she try this odd, new method. He asked her to think about the rape and note her distress on a scale of 1 to 10. Eight to nine, she said and began sobbing, but followed the tapping instructions anyway. After a few minutes, Gallo says, "she settled down, looked more composed and began drying her eyes. I asked her how she felt, and she said, 'Fine—it doesn't bother me, anymore.'" Describing the session herself, the woman remembers that, although it took "quite a while"—eight to ten minutes—"the scale came all the way down. I was dumbfounded. [The suffering] was gone. . . . [The rape] was like a snapshot, just there, but it didn't mean anything. It wasn't a feeling of numbness, just acceptance of something that had happened to me, nothing I did had caused it and it was over." ■

GOING FOR THE THE CURE

continued from page 25

searchers don't sanction very much of any practical interest to psychotherapists. So about three years ago, Figley undertook to bridge the gap between research and practice by setting in motion an unusual research project, for which he had only a few modest goals: finding a "cure for PTSD," putting an end to compassion fatigue, stimulating new studies and transforming the entire methodology of psychotherapy research.

IN EARLY 1993, FIGLEY AND PSYchology professor Joyce Carbonell, a colleague at Florida State, began to send a "clarion call" to the clinicians of the world for "nominations" of PTSD treatments that practicing therapists found worked the best, regardless of whether they were orthodox, validated, standardized, FDA-approved or off-the-wall. To be included in Figley and Carbonell's "active ingredients" project, a systematic clinical demonstration defined as a "user-friendly research methodology that is a collaboration between practitioners and researchers," the methods had to meet several criteria: the approaches had to have been demonstrated to be "extremely efficient," producing within a few sessions an "extraordinary impact on clients' progress in recovering from PTSD," and their effectiveness had to be verified by 200 to 300 licensed or certified clinicians who had actually used them to treat PTSD. Further, the inventors of the methods had to be willing to come to Florida State for a week and publicly show their stuff with assigned clients in a laboratory setting (two to four sessions per client, while being videotaped and watched by area therapists), then stick around for discussions and conferences devoted to uncovering the meaning of it all. Was there an identifiable "active ingredient" common to different successful treatments that made them effective? Would finding this ingredient help develop a theory that explained both the induction and reduction of trauma?

Severely traumatized clients challenge not only the effectiveness of standard therapies but their relevance—as if ordinary clinical interventions were trivial in the face of suffering beyond the pale of any neat diagnostic category.

Gathering the nominations was an informal, democratic, if not very systematic, process. The message went out to about 10,000 people via Interpsych, the Internet special-interest group consortium, as well as to hundreds of others contacted by more traditional means, through conferences, symposia, workshops and the professional grapevine. An advisory board of specialists in traumatology screened the methods for treatment possibilities, plausibility, interest and adherence to the inclusion criteria. Only four methods made the final cut for the scheduled clinical demonstrations. However obscure to the official world of psychotherapy, they had nonetheless all been around in one form or another for at least 10 years—one for about 20. Undoubtedly less surprising is that all originate in California.

The best known, and probably for that reason the most hotly debated, Eye Movement Desensitization and Reprocessing (EMDR), was developed by psychologist Francine Shapiro. It involves

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visual, auditory or kinesthetic stimulation while the client focuses on the traumatic material and integrates it. Another chosen method was the relatively conservative Trauma Incident Reduction (TIR), a desensitization and cognitive imagery approach refined in the mid-'80s by Frank Gerbode, a California psychiatrist. In this approach, the client is directed to review a traumatic incident, first silently, then aloud, over and over again in the presence of an interested but neutral "facilitator," until arriving at an internal resolution. The third method, Visual Kinesthetic Dissociation (VKD), demonstrated by Florida therapists Maryanne and Edward Reese, is related to Neuro-Linguistic Programming (NLP)—an approach to human learning and change based on close analysis of verbal, behavioral and sensory patterns developed in the early 1970s by Richard Bandler and John Grinder. With VKD, clients are led through a process of purposeful dissociation, in which they visualize watching a movie or TV program of themselves undergoing the traumatic event. During the process, they imagine communicating with and reassuring their younger, traumatized selves and integrate the entire experience into their present lives. Thought Field Therapy (TFT), possibly the least therapy-like therapy ever invented, created by California psychologist Roger Callahan during the early '80s, requires only that the client think briefly about the traumatic event while specific acupuncture meridian points (supposedly stimulating the body's bioenergy system) are tapped or rubbed. (For detailed descriptions of each approach, see pages 25-29.)

It cannot have been an easy decision for the innovators of these so-called "alphabet therapies" to participate in the project. On the one hand, they had nothing to lose and everything to gain from the study; with the exception of EMDR, none had sufficient name recognition to have much of a reputation, bad or good, and had nowhere to go but up. Even EMDR, with more visibility, but facing more organized opposition, stood to benefit enormously from being included in a high-profile project initiated by one of the world's leading traumatologists in an established university setting. On the other hand, the innovators were aware that their therapies were on trial before an international audience and expected to produce results in one to four sessions for treating unknown, unselected, formally undiagnosed and largely unprepared clients. "It was scary," says psychiatrist Frank Gerbode, whose team demonstrated Traumatic Incident Reduction in the project. "Up to that point, TIR was still relatively unknown, and its reputation rested on how good a showing we had—this was it, the showdown at the OK Corral."

In the popular mind, innovators are expected, even required, to have a hard time convincing the world that they have a better mousetrap, even if they really do—embattled genius struggling against philistinism is inherent to the myth of creativity. And yet, until recently, psychotherapy has in fact been remarkably open to new ideas. But this traditional attitude of laissez faire is going the way of private practice, as the old freedoms of clinical work sink rapidly under the pressures of the media (which often depicts therapists doing nothing but extracting false memories from helpless clients) and the movement toward stricter practice guidelines, promoted by the burgeoning managed care industry. The current climate of distrust of therapy has made it much harder for innovation to flourish, and much, much harder for innovators to get a hearing.

Roger Callahan, for example, has already undergone his own ordeal by fire, even before heading for Tallahassee. Having had a successful career as a psychology professor, publishing papers and chairing meetings, he suddenly found himself a pariah when he tried to introduce Thought Field Therapy to a wider audience—his papers rejected without comment or advice, his requests to give workshops denied, his own practice investigated by the California state board for ethics violations (he had used the word *cure* in discussing his work)—inquiries usually reserved for egregious sexual and financial wrongdoing. ("As a matter of fact," says the irrepressible Callahan, "they closed the investigation, when I did the technique on the investigator and cured her of a phobia.") Last August, at the annual meeting of the American Psychological Association in a workshop Figley led on the "active ingredients" project, after the four innovators had presented their methods, a man in the audience stood up, roundly castigated all four approaches, then pointed a finger at Callahan and said, "As for you, Dr. Callahan, if I were a patient of yours and you were doing that kind of crap to me, I'd sue!" Callahan says he expects militant skepticism, but doesn't understand why he has faced such relentless hostility and antagonism.

But hostility and antagonism are

what innovators can expect to dine on these days, if they become successful and appear to be making a serious dent in the zeitgeist. Quietly advising moon worship as a psychological treatment might not rouse much interest, as long as it remains buried in the mossy overgrowths of some New Age grotto, but once the word gets out, warning antennae begin to quiver around every psych department in the country. In the battle for legitimacy that an expansive and vastly popular EMDR movement is waging, academics routinely accuse EMDR's Francine Shapiro and her associates of almost every egregious ethical and professional sin in the APA manual, except sexual abuse of clients. EMDR proponents, they say, make unsubstantiated claims about the benefits of the method for personal gain, exaggerate tentatively positive research findings on its behalf while ignoring or suppressing negative reports, prevent verification of EMDR techniques by independent researchers and aggressively market to the public a treatment that has little or no empirical backing.

For example, in one of numerous academic broadsides, "EMDR as Marginal Science," a review of Shapiro's 1995 book about EMDR published in the March 1996 issue of the *Scientist Practioner,* William O'Donohue and Steven Thorp of the University of Nevada in Reno accuse Shapiro of engaging in "pseudo science" and intellectual dishonesty. "We found the explanation of how EMDR works to be a paradigmatic example of the use of scientific-sounding terms to give the aura of science to what is actually babble." Clinicians have picked up on Shapiro, the authors suggest, because "the field of psychotherapy has been none too particular about the evidential credentials of psychotherapies and assessment devices."

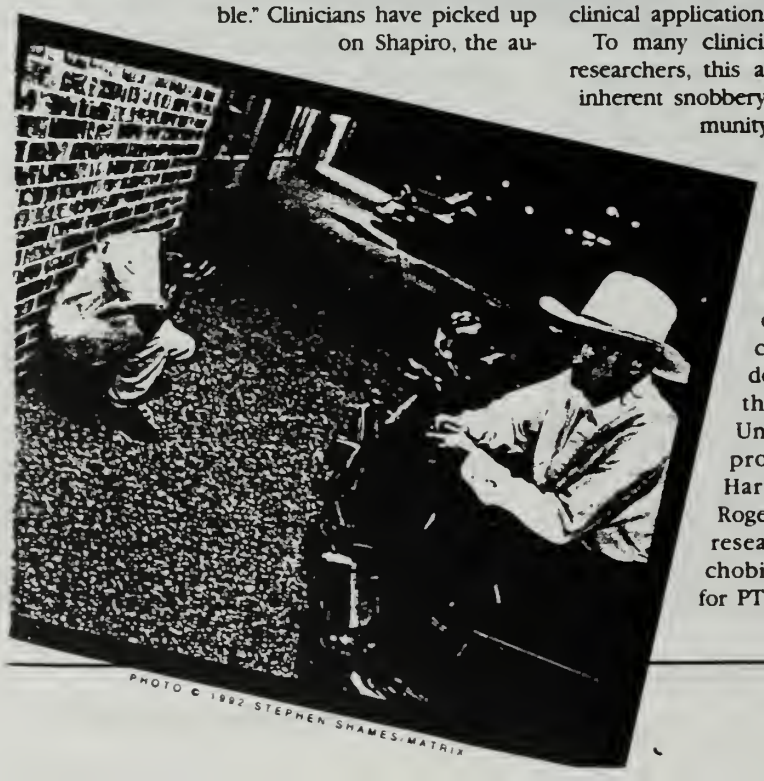
Although Robert W. Montgomery, a professor in the Department of Psychology at Georgia State University in Atlanta, had reported favorably on EMDR in a six-subject study he had done with colleague Teodoro Ayllon the previous year in the *Journal of Behavior Therapy and Experimental Psychiatry,* in his review of her book the following year for the same journal, he accused Shapiro of pervasively misrepresenting and misinterpreting research literature, taking a "self-aggrandizing" tone in the text and making "grandiose" claims about EMDR. In an extensive review article, which appeared in the *Journal of Behavior Therapy and Experimental Psychiatry,* academic critics Jeffrey Lohr, Ronald Kleinknecht, David Tolin and Richard Barrett summed up the results of more than 60 research studies on EMDR, writing that "the results of controlled experimental research provide little in the way of support for EMDR clinical applications."

People want one or two simple formulas to use with everybody, but no two people experience PTSD the same way—and we aren't going to find one quick fix that works for every client.

To many clinicians, and even a few researchers, this attitude embodies the inherent snobbery of the research community. "They [the academic establishment] are holding EMDR to an unfair standard, and requiring more in the way of proof than is normally required, simply because the method doesn't make sense to them," says Temple University psychology professor Jay Efran. Harvard psychiatrist Roger Pitman, an eminent researcher into the psychobiology of treatments for PTSD, once deeply skeptical about the procedure, now believes "the mounting body of evidence in the literature that suggests something about EMDR is effective. . . . Too many people say they have had good experiences with EMDR to completely poo-poo it." But Pitman is still inclined to dismiss the odd identifying feature of EMDR—the alternate stimulation (the eye movements, or presumably any other)—as "unproven speculation."

The debate about EMDR seems in part an outgrowth of an old quarrel between "town and gown"—a de facto class antagonism in the psychology profession that pits higher-status academics against practitioners. Clinicians widely believe that academics regard them as less talented, more often drawn from the lower ranks of psychology students, whose judgment about new methods is more likely to be swayed by "clinical intuition" (i.e. emotionalism) than rational logic and empirical demonstration. "There is a real disdain for clinical work [among researchers]," says Jean Steinberg, who did her graduate work in the prestigious behavioral psychology program at State University of New York at Stony Brook. "At Stony Brook, those of us who wanted clinical positions were steered toward more academic ones. There was a definite sense that clinicians were second-class students and second-class professionals."

What Figley and Carbonell were trying to do with their active ingredients project—accommodate the hard rules of science to the infinitely fluid circumstances of life, without fatally compromising the first or misrepresenting the second—sounds eminently reasonable. Yet the line between a tyrannical scientific methodology, on the one hand, and a sloppy disregard for all rules of evidence on the other can seem impossibly narrow. Without some standardized, controlled research on therapy techniques, how can clinicians separate the good from the bad from the indifferent among scores of



therapeutic "breakthroughs" carried aloft by popular appeal? Yet, when the mushy core of most human experience is ignored, science can degenerate into crude scientism—an infatuation with scientific style paradoxically undermining the value of research itself. Economist Paul Krugman, in his book, *Peddling Prosperity*, suggests that the problem with most economists is that "they want a subject that is fundamentally about human beings to have the mathematical certainty of the hard sciences," which is a mistake, he writes, because human beings "do not behave in simple, mechanical ways." How much truer are these remarks about the scientific attempt to extract unambiguous truths from the almost legendary ambiguities and complexities of psychotherapy?

People who actually do therapy take the command to be more scientific with a grain of salt; they know that therapy today still depends more on relationship than method. "I think Therapy with a capital *T* doesn't work," says Jay Efran. "*People* work—therapists work and clients work—and they find interesting and useful ways to work together. But when we try to turn therapy into a thing, reify it, then I think we are looking for something unreal."

Indeed, the hunger for certainty can actually compromise the search for truth. One psychology professor at a well-known university research psychology department says that the controlled validity studies he has seen make him cringe. He reports that inexperienced students, who are assigned to treat the experimental clients for the lead investigators according to rigid manualized treatment protocols, frequently stop using the method being tested after the first session because it seems to have so little relevance to the client's problems and offends the therapist's sensitivity. "Everybody knows there is a lot more going on in the therapy room between two people than is contained in a treatment formula," says this professor. The students end up doing more or less regular, ad hoc therapy, then "write it up as if the manual did the trick. It's practically fraud."

The trick is to get the brain focused on the thought evoking the old emotions and feelings, and introduce something that reduces the anxiety associated with it—to extinguish hyperstress with hypostress.

HOW CAN A RESEARCH PROJECT be designed that encompasses both scientific research and clinical care, and produces research that means something to members of both worlds? The task of Figley's clinical demonstration was fundamentally to bring the clinic into the laboratory, to demonstrate real therapies on real clients, but in a sufficiently rigorous and controlled way that some empirically valid conclusions (or at least suggested conclusions worth pursuing) could be drawn from the process.

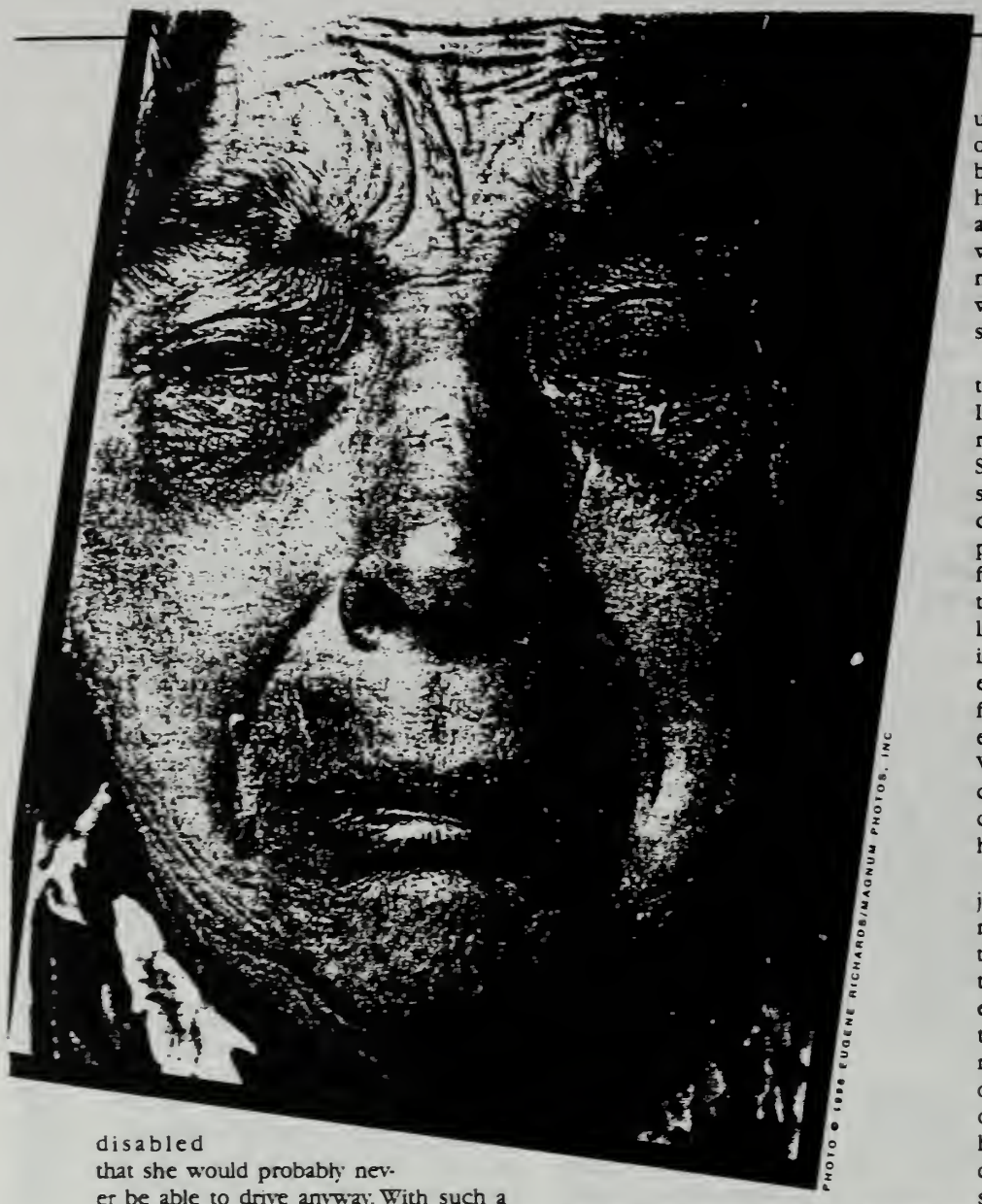
To make the study actually relevant to real practice, Carbonell and Figley bypassed many of the usual academic safeguards. Not only had the investigators chosen treatments largely unknown and likely to raise suspicions in the research community because of their oddness and general lack of orthodox empirical support, they were not very picky about either the provenance or diagnostic profile of the client-participants who would be included in the study. When publicizing the project, Carbonell and Figley cast their net wide for subjects, recruiting them from the entire Tallahassee area (not limiting the study mainly to university students or known clients of their own colleagues). They sent our their call for participants by radio announcement, newspaper story and word of mouth.

Nor did they demand anything as specific as an actual diagnosis of PTSD, or even particular symptoms. They called only for people suffering the aftereffects of a trauma, whatever that might mean, or a phobia, on the theory that many phobias are embedded reactions to trauma. These were "real clients, self-selected, of incredible variety" says Carbonell. Ultimately, 51 people were chosen and screened (none were admitted who were retarded, psychotic or taking heavy-duty neuroleptics), tested (various psychological "pen and paper" questionnaires and physiological measurements) and assigned in the order they had come to the next available teams of innovator-clinicians, who were allotted no more than four sessions during one week each in mid-September, October, November and December 1994.

The majority of the participants were women, median age 40, with just under 16 years of education. Although the most common presenting problem comprised unresolved issues from childhood abuse (about 38 percent), the rest were a hodgepodge—Vietnam and Gulf War veterans; crime, rape, domestic violence and accident victims; people suffering bereavement or losses (including job loss, divorce, major family health problems, the unresolved death of a parent during childhood); one person who had returned from prison to find his personal network completely gone; and people with various phobias (including a woman terrified of blood, another of snakes—but "only snakes falling out of things," says Carbonell, "a snake-from-the-air phobia!").

The project was as rocky, unpredictable and full of unexpected vicissitudes as any typical therapy experience times 51, with the additional complications of the research requirements. In the end, 39 made it through treatment. One male participant, learning that he would be assigned to VKD, protested that he wanted the one with the waving fingers; assigned to EMDR, he quit anyway because, he said, he "didn't wish to think about" his trauma. Two or three, who had denied using psychotropic medications during screening, later revealed otherwise—one, when asked again during the first session if he was taking medications, replied, "nothing except thorazine."

Some seemed to qualify as "traumatized" only in the broadest sense. One man, for example, complained of marital problems, though he said his *wife* thought he might have been abused as a child; a woman felt anxious about reentering the workplace after a long absence; another couldn't decide whether or not to get out of a family business. Others seemed poor candidates for brief treatment of any kind—a couple of clients who appeared to have dissociative disorders, a woman with a driving phobia who was so physically



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that she would probably never be able to drive anyway. With such a typical, heterogeneous client population, there must have been times when the investigators wished for the nice, homogenous, if strangely exotic, populations of one-phobia-and-nothing-else clients with whom their lucky colleagues conducted normal research projects. One major measurement of improvement, for example, was the Subjective Unit of Distress (SUD) scale—a self-report on a 1-to-10 scale of emotional pain and discomfort, obviously susceptible to the vagaries of mood and happenstance—provided by all participants before and every day for six months following the demonstration. But how could the investigators determine the impact of treatment, using this scale, on a woman who measured about a 5 on the SUD scale when she began and a 10 (the highest measure of distress) after her first treatment? Upon questioning, the woman admitted she felt much better about her problem, but sitting in the same room for an hour with "that man" (the therapist) had upset her. She had neglected to tell the screener that she did not like men, period. When measured sometime later—after the upset of being exposed to the opposite gender had worn off—her SUD level had come down to a 3.

And how could the investigators elicit treatment effects when the measurement devices proved so susceptible to personal idiosyncrasy? The participants had agreed to keep daily diaries, receive weekly phone calls from the team and return for a six-month follow-up visit. After being treated, however, some announced they now felt so much better, they no longer needed treatment, thank you very much, nor did they wish to receive phone calls or return to the clinic—17 refused to come back for the six-month "check-up." When Carbonell pointed out to one participant who wouldn't come back that she would forfeit the fee she had paid for treatment (to be returned after the six-month follow-up), the woman replied, "That's okay; it wasn't much money and I don't need it, anyway." One of the later refuseniks, the snake phobic, was herself a therapist.

The diaries produced their own interesting, not always apposite, data. Intended to reveal how the participants rated their trauma or phobia-related SUD on a daily basis, the entries showed a good deal of what Carbonell calls "drift"—reflecting the difficulty people have separating the special suffering that brings them to therapy from the ordinary ups and downs of normal life. A participant who came in reporting a history of child abuse might, for example, record for one day, "Felt no fear, no terror—pretty good day," while estimating a very high SUD level of 9. When Carbonell asked about this discrepancy, the response was that on that day, she had a flat tire and was two hours late for work.

Both during and long after the project, the innovators grumbled about its research methodology and each other: the clients were too heterogeneous, their symptoms too severe, not severe enough, unsuited to their treatments; there had not been adequate or accurate description of the real conditions of the project; this or that circumstance of the project (which the others didn't have to undergo) prevented them from doing their very best work; there were signs of favoritism (to somebody else); there was not enough time to prepare clients adequately, or there was too much time, leaving them sitting around twiddling their thumbs.

The EMDR clinicians aroused a certain amount of agitation by presumably "picking and choosing" their clients—rejecting those they didn't like. Nothing like it, says Steven Silver, one of the EMDR demonstrators; a woman who had been raped was assigned to EMDR, but refused to be treated by a man, so he referred her to the clinic. Others they declined to treat, said the EMDR demonstrators, because they were clearly unsuitable and it would have been unethical and possibly dangerous to continue. One, for example, was a dissassociative client, for whom Roger Solomon, the second member of the EMDR team, felt the treatment might stir up more intense issues and emotions than she could handle without

continuing therapeutic support. Still, the other demonstrators then wondered if perhaps they shouldn't have "turned down" some clients, as well.

If the EMDR contingent aroused the most heart-burnings because of their alleged cherry-picking, they were also the most dismayed by the project's heterodoxy. They objected to the inadequate diagnostic guidelines ("most of the clients didn't even have PTSD," says Shapiro) or clear, systematic protocols; the failure to include more standard (and reputable, one suspects) brief therapies (like flooding or some cognitive-behavioral technique); and the conflation of EMDR—which they consider a comprehensive therapy—with three treatments targeted more to specific trauma symptoms. "The conception of the project was admirable, the decision to use highly trained clinical demonstrators worthwhile," says Shapiro. "But in the absence of scientific rigor, people will misunderstand the meaning of the outcomes. The field is not going to be swayed by this; few academics, or scientists or sophisticated clinicians will be impressed. The whole thing was a mush."

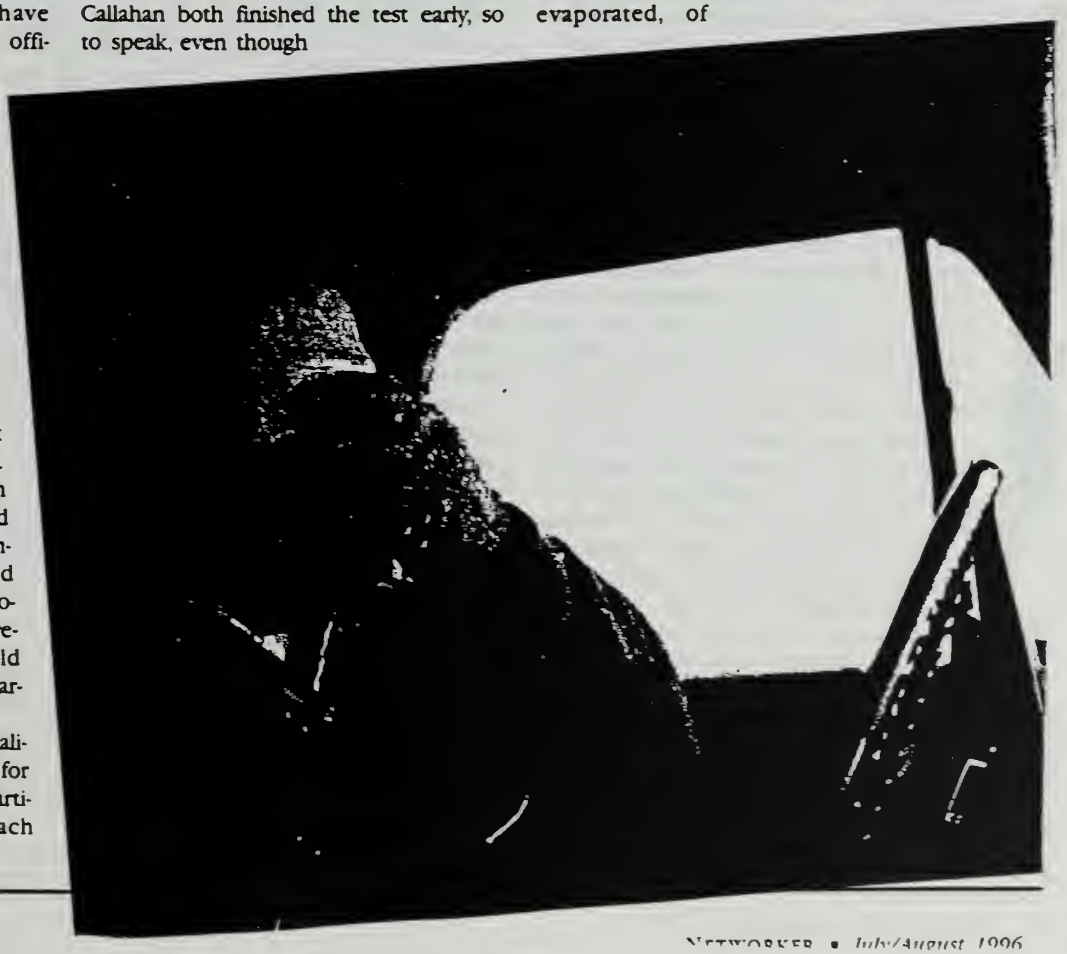
It is also hard to escape the impression that Shapiro finds it maddening to see her method cast once again into the netherworld of unrecognized, unorthodox, largely untested and unpublished clinical arrivistes who have barely started up the hard trail to official legitimacy. Shapiro has spent eight years of unrelenting effort trying to wrestle EMDR into the family of standard professional and scientific psychology, pushing more strenuously for empirical research than any other mental-health-care innovator in recent history (outside the pharmaceutical industry). She has provided free EMDR training to researchers and trained more than 18,000 clinicians in her approach, which has been the subject of at least 60 clinical research studies. Still, the waves she has made in the field with her outré method and the resistance she has encountered has not particularly surprised her. "It's just what [science philosopher] Thomas Kuhn says," she remarks with resignation. "The old guard has to die off before new paradigms are finally accepted."

In all, what with dropouts, disqualifications and failures to come in for follow-up, the actual number of participants assigned to each approach ranged from 6 to 15 (EMDR 6, TIR and VKD 9, TFT 15) who actually made it through the entire process. The average time required to achieve results by each method ranged from a high of 254 minutes (TIR, which requires the clients to talk more) to a low of 63 minutes for TFT. The VKD technique, involving a somewhat extended visualization process, took 113 minutes to complete.

EMDR demonstrators said they had used more time (an average of 172 minutes) than they really needed simply to relieve symptoms, because they felt obliged for ethical reasons to try and do what they normally did—go through an elaborate eight-phase treatment protocol. This allowed them to get to know and prepare the client, decide on target events, treat both the target issue and anything else that came up and provide for closure and reevaluation.

If it had been a horse race, which the investigators as well as the innovators were all at pains to deny, the TFT contingent would have won, hands down. Requiring virtually nothing in the way of personal interaction, TFT can bypass all that tedious therapeutic business of joining, empathy, history-taking, reprocessing and the like, and zero in on the problem immediately at hand. With 10-minute treatments not at all unusual (comparatively long, actually), Roger and Joanne Callahan both finished the test early, so to speak, even though they said they were the last ones assigned clients and got the "dregs, including several patients whom other therapists could not help, even one psychotic." Still, says Roger Callahan, "We didn't have enough people, and could have taken a lot more, so we just spent a lot of time chatting [with clients]." They might have produced even more impressive results, he continues, "but we only went in at a third of our power. We understood the treatments we showed were supposed to be those that the average [para- or non-professional] person could do. Afterward, we heard that the others ignored this, and went in with their best shot. We had much more powerful recipes we could have brought to do even better."

WHEN CARBONELL AND FIGLEY began what they called their "star search," they wanted to get talented but unsung newcomers out of the strawhat circuit and bring them to Broadway. Once the innovators had demonstrated their stuff before a tougher audience than the usual workshop crowd, the investigators hoped to learn more about trauma, stimulate further research and, finally, perhaps uncover some sort of "active ingredient" or powerful antidote to PTSD common to all four approaches. The possibility of achieving any of these goals would have evaporated, of



course, if the methods had proven themselves duds at Florida State. Luckily, they did help, though the improvement, like the study itself, resists easy classification and quantification.

According to symptom inventories administered at the beginning of the study, the client participants were typical of the outpatient mental health population. In addition, their average ratings on the SUD scale before treatment ranged from 5.0 to 6.5 (5.0 for EMDR, 5.4 for VKD, 6.09 for TFT. 6.5 for TIR)—moderately high, but not unbearable, degrees of pain. Immediately after treatment of one to four sessions, these ratings came down to between 2 and 3.5 for three of the four methods (2 for EMDR, 2.8 for TFT and 3.5 for TIR). VKD's average SUD score of 5 was skewed by the assignment to the unfortunate male therapist of the woman who hated men and reported a SUD of 10 right after treatment, even though her actual trauma-related symptoms improved substantially, and VKD's overall score later dropped to 3. After six months, all the clients' SUD scores were still lower than before treatment, though they had begun to creep up to between 3 and 5 (3 for EMDR, 3 for VKD, 3 for TFT and 5 for TIR). The increase probably reflects what might be called successive attacks of "bad-day syndrome"—the spiking of daily scores related to life troubles that had nothing to do with the presenting problem.

There were other markers of improvement; the symptom inventory, a separate measure from the SUD scale, which averaged around 50 for all participants, came down on average by 7 to 9 points (9 for EMDR and TIR, 7 for VKD and 8 for TFT). All the clients seem to have improved, some dramatically. One woman, a survivor of childhood abuse, treated with TIR by Teresa Descilo, was so transformed by her first session that nobody on the research team recognized her when she came back for her second appointment. In the few days between, her clothing style, hair color and mood had changed dramatically, and she had gotten a new job. The woman with snake phobia began gardening again—something she had not done in years—although the downside to her improvement was her husband's disgruntlement at having lost his role as her protector from snakes. Another woman, who had been terrified of going out or staying alone since an assault, could now be by herself without fear and began to enjoy an active social life.

PHOTO © EUGENE RICHARDS

The project bore little resemblance to a typical clinical trial—there were no controls (clients assigned to no treatment, for example), diagnoses were not standardized or even particularly reliable, numbers of participants completing the entire process varied substantially among the methods, self-reports in the diaries were idiosyncratic—nor was it intended to be a comparative study of which approach worked best. Rather, the project was a pioneering attempt to demonstrate four new methods of treatment on a typical client population within a laboratory setting under as stringent a set of experimental conditions as possible, given very unstringent circumstances.

In most instances, people with chronic PTSD are just giving up, learning to organize their lives around their disability. And the blame for this has to be laid at the feet of those of us who call ourselves experts.

Even so, "not one client who participated in the project failed to benefit," says Gail Davies, director of the psychosocial stress clinic at Florida State and responsible for administering the project. Did the project find a "cure for PTSD," its purported goal? Figley himself seems to have initially used *cure* as a bit of energizing hyperbole to nudge the establishment out of its doldrums. Yet quoting the dictionary, he says, a cure is "a method or course of remedial treatment," as well as a "restoration to health." A cure "eliminates troublesome symptoms of trauma," he adds. "Being cured means that clients have gained control over their problems, though they may not have eliminated them completely." Using this definition, some participants do appear to have been "cured" of their traumatic symptoms, even if the approaches did not immediately end chronic depression and loneliness, imbue people with relationship skills they didn't have before, drain away all shame, guilt, anger and self-dislike.

"People want one or two simple formulas to use with everybody, as if all clients were the same," says Davies, who uses all four new methods in her own work. "But no two people are alike and no two experience PTSD the same way—and we aren't going to find one quick fix that works for every client. These new approaches are techniques and tools, but not the whole therapy." Nonetheless, says Davies, the so-called "power therapies" seem to "jump start the process of therapy. They move clients along much more quickly through their trauma to a resolution. You can cover more in a single session than in a month of weekly talking."

What about the "common ingredient" Figley had hoped to discover—did the project uncover the psychotherapeutic equivalent to Ariadne's thread? A hypothesis *has* emerged from the study. According to Figley, what all the methods have in common is that they pair the thought of the traumatic event with the sudden dramatic reduction of physiological anxiety, and something like a new neural connection is made between the memory of the trauma and a calmer, more tranquil physical state. Trauma produces a chronic state of "hyperstress," caused by the massive emission of stress hormones (see "The Biology of Fear" page 38); the four approaches all produce a calming effect on the body—"hypostress"—while the brain is actually mentally reliving the trauma. Says Figley, "The trick is to get the brain focused on the thought evoking the old emotions and feelings, and at the same time introduce something that reduces the anxiety associated with it—to switch the program. The idea is to extinguish hyperstress with hypostress."

Well, maybe, but the innovators of the new approaches seem lukewarm to a single, rather simple explanation. "Basically, Charles is saying that every time a person looks at a trauma in a safe environment, the stress is reduced," says Frank Gerbode, the inventor of TIR. "I'm not enthralled. Theoretically, Figley's hypothesis means that you could cure PTSD by putting somebody on an anti-anxiety drug [which you can't]. Besides,

any therapist worth his or her salt produces hypostress during a session." VKD practitioner Maryanne Reese believes that there are more likely many active ingredients involved, rather than just one. "We don't believe the hypostress-hyperstress hypothesis is the active ingredient," says Joanne Callahan of TFT. "All the old methods get people to focus on the trauma, and they don't work. We think the new approaches are dealing with the body's underlying energy systems." To Francine Shapiro, Figley's explanation radically oversimplifies EMDR—in which she believes the eye movements and the reduction of traumatic symptoms are only part of a more comprehensive cognitive and emotional restructuring. "EMDR is not just a technique that just gets rid of a certain amount of disturbance," says Shapiro. "We try to get in as many changes as possible—awareness, insight, new goals for the future."

Carbonell and Figley plan to carry on their project, showcasing both the famous and the obscure among brief approaches to PTSD. Solution-focused and narrative therapies are next on the agenda, and so is something called the Tapas Acupressure Technique (TAT). Developed by Tapas Fleming, an acupuncturist with a background in yoga and Taoism, TAT involves placing two fingers at either side of the nose between the eyes and the other hand firmly against the base of the skull while thinking about the trauma. Publicized via the Internet Trauma Forum, the method was tried by several therapists, who liked it. The opinion among those Figley polled was on the order of, "Well, it's no wackier than TFT, so why not try it?"

NOTWITHSTANDING THE NOISY opposition to EMDR, and probably, soon, the other three therapies given new visibility by their inclusion in this study, the response to Figley and Carbonell's research seems more bemused fascination than outright hostility—like watching somebody cross Niagara Falls on a tightrope in a thunderstorm. One colleague recently told Figley, "Well, Charles, I would laugh at anyone else doing this, but you may just have a shot at it." Conservative peers are occasionally a bit more blunt with Carbonell—one psychologist asked her if she and Figley "had any validated research to back up that crap you're studying." Carbonell responded by asking him if *he* had any validated research to back up his own habit of one-hour-a-week talk therapy. The cautious response may suggest the fugitive hope, particularly at a time when the economic zeitgeist demands ever shorter therapies, that there might just be something to this new, new wave. The promise of brief, cheap, effective treatments to dangle in front of the eyes of managed care executives is strong incentive for open-mindedness.

What worries some therapists is the danger of forgetting that trauma never happens exclusively inside the individual. It is inextricably embedded in a family and social context.

And yet there are good grounds for being cautious besides the ambiguities of the project itself—one being a decent regard for psychotherapy's checkered history. Jay Efran remembers the appearance some years ago of a new psychotherapy approach—it doesn't matter which one, the story is legion—that showed extraordinary promise. Therapists who used the method, which was amazingly simple, reported clients making faster gains than they had after years of more conventional treatment. There were testimonials and case histories of miraculous turnarounds; followers flocked to weekend trainings, newsletters sprang up, a book or two were published. But then it was found that for certain difficult cases, the method required longer time to work and more integration with standard practices. Eventually, *most* people who received the new treatment were found to be "chronic," with "deep-seated" issues or attitudes not amenable to speedy cures. In the end, says Efran, the method became largely indistinguishable from any other therapy modality, where it putters on to this day. Says Efran, "We could pull together a whole string of these things, which, as they become known, show themselves to be little different from the ones that went before." On the other hand, Efran is not immune to hope, either. "I still can't resist being intrigued," he says. "What if I paid no attention to something like TFT and it turned out that it worked? I wouldn't want to miss it."

What worries some therapists more than the scientific issues, however, is the possibility that by emphasizing the quick, symptomatic fix, the field is in danger of forgetting that trauma never happens exclusively inside the individual. It is inextricably embedded in a family and social context, and inevitably raises moral and spiritual questions about the whole meaning and purpose of life. "Therapists feel great urgency to provide immediate symptom relief to people in pain," says Washington, D.C., therapist Jeffrey Jay, "but if they don't also address the client's question, 'Why did this happen to me?' they ignore a critical part of his or her suffering, which is about meaning, that requires us to look at the religious and moral community in which the trauma occurred."

In the experience of some trauma therapists, PTSD cannot be adequately treated without addressing broader social, political and spiritual issues, as well as the individual psychological suffering and neurophysiologically based stress reactions. "The trauma of Vietnam vets was not just about killing or experiencing the fear of being killed, it was about an unpopular war and coming home to a country that didn't support them," says trauma therapist Mary Jo Barrett, director of training and consultation at the Center for Contextual Change in Skokie, Illinois. Similarly, Barrett argues, the trauma of childhood sexual abuse is bound up with strong moral and religious taboos about sex and a social climate in which the child's fear of telling is matched by the unwillingness of adults to listen. Barrett, who treats both sexual abuse victims and perpetrators, combines individual and family therapy, encouraging clients to write stories or poetry, as well as renew their spiritual resources. Perpetrators are required to do community service—help other offenders, give talks to victims' groups, engage in political work against sexism and racism.

Still, therapists yearn for something that will at least break the impasse that

keeps people with PTSD too overwhelmed by their symptoms to even begin engaging in therapy. Trauma therapists report trying the new methods only because near-despair overcame skepticism. "I had no confidence EMDR would work," says Nanci Barthel, a therapist with an agency in Oklahoma City who took free EMDR training offered in the wake of the 1995 bombing. "But I was at the point that I didn't think I wanted to be a therapist anymore. I had such severe caseloads, with so much trauma, and I felt so ineffective." Both EMDR and TIR, which she also learned, changed her life, she says, vastly improving her therapy results. "I can help people move beyond mere survival to improve the quality of their lives—they are not just managing the trauma, they have moved beyond it." Kate Sorensen, the therapist who found work on a Navajo reservation so dispiriting she nearly left therapy several years ago, has also seen her practice reborn after learning all four new methods. "These approaches have changed both my work and my life. Getting in touch with people's suffering when I *can* help them is a thrill. It's the difference between burnout and joy."

These reports, heard over and over, sound like stories of conversion and salvation—first I was lost, then I was found—that have been too easy for skeptics to dismiss as so much pseudo-religious hot air. Clearly, something "real" is happening—to simply reject out of hand the experiences of hundreds of thousands of clients and therapists because empirical trials are lacking seems perverse—but what, exactly, is happening isn't so obvious. Perhaps the four approaches will indeed prove to be avatars of a continuously prophesied "new paradigm" in therapy (though Frank Gerbode argues that the field doesn't yet have a commonly agreed upon *old* paradigm), transforming theory and practice.

But whether or not the "power therapies" will still be around in five years, let alone revolutionize the entire psychotherapeutic worldview, the glowing reports suggest they provide something critical to the practice of therapy: they instill in therapists a sense of confidence and mastery in their own capacity to help people, a feeling of hope that even presumably "hopeless" clients can recover, which is perhaps their most important tool. "I always felt these [traumatized and severely disturbed] clients were unreachable, untouchable, that I wasn't able to address their problems," says Barthel. "But when I took these trainings, I found myself staring hope right in the face—hope, which I had never had before, that there are ways to resolve these problems."

Healers must believe in themselves and their therapy, writes Harvard medical anthropologist Arthur Kleinman, in order to stimulate feelings of belief and hope in their clients. This benign mutual collusion in belief and hope, a kind of healing covenant between doctor and patient, therapist and client, is the source of the so-called placebo affect—a powerful curative agent in its own right (an estimated 10 to 90 percent improvement rate for medical conditions are due to placebo) that has been wrongly dismissed as an annoying epiphenomenon, a kind of ugly stepsister to "real" treatment, in both physical and mental health care. Certainly, the innovators are unsurprisingly loath to see the word placebo coupled with their own methods, because it connotes something inert, innocuous, accidental, unreal. Roger Callahan even maintains that because TFT arouses so much skepticism in clients, it doesn't get its fair share of placebo cures—thus he vouches for its "real" efficacy. And yet, therapists who insist upon their prior skepticism about a new method, and then try it anyway, are more hopeful than skeptical from the beginning, as are the clients who give their assent. Indeed, the toughest-minded skeptic is skeptical about skepticism itself. At heart, all clients and therapists must share some flutterings of hope, even if secret and unadmitted, before embarking together on something new. This willingness to try something new, again and again, this refusal to be beaten down by misery and despair is, finally, the most important "active ingredient" of any therapy. ■

Mary Sykes Wylie, Ph.D. is Senior Editor of The Family Therapy Networker.

ON A HUMID EVENING last September, Susan and James burst into our office looking like two high schoolers in the grip of a classroom giggle fit. Usually serious and reserved, James, 36, explained between chuckles that he had been telling Susan a story about his boss's gaffe at a meeting earlier that day. Still chortling as she landed on our office sofa, 27-year-old Susan ran her fingers through her cropped, blond hair and tried to compose herself, then eyed her gleeful husband and began hooting all over again. I glanced at my wife and cotherapist, Lisa, for a microsecond and gave her a raised-eyebrow version of a high five: This had all the earmarks of an easy session. ❡ After a bit more banter, we steered the conversation to the main order of business—the state of their six-year marriage. Susan began to recount an incident

The Emotional Imperative

PSYCHOTHERAPISTS CANNOT AFFORD TO IGNORE

by BRENT ATKINSON

that had occurred a few days before, when James had volunteered Susan to drive his daughter to a birthday party so that his ex-wife wouldn't be inconvenienced. "I felt used," Susan said bluntly. So far, so good, I thought—she is simply stating her feelings. Then, looking directly at her husband, she continued: "But what upset me even more was your reaction when you saw that I was unhappy. You started defending her!"

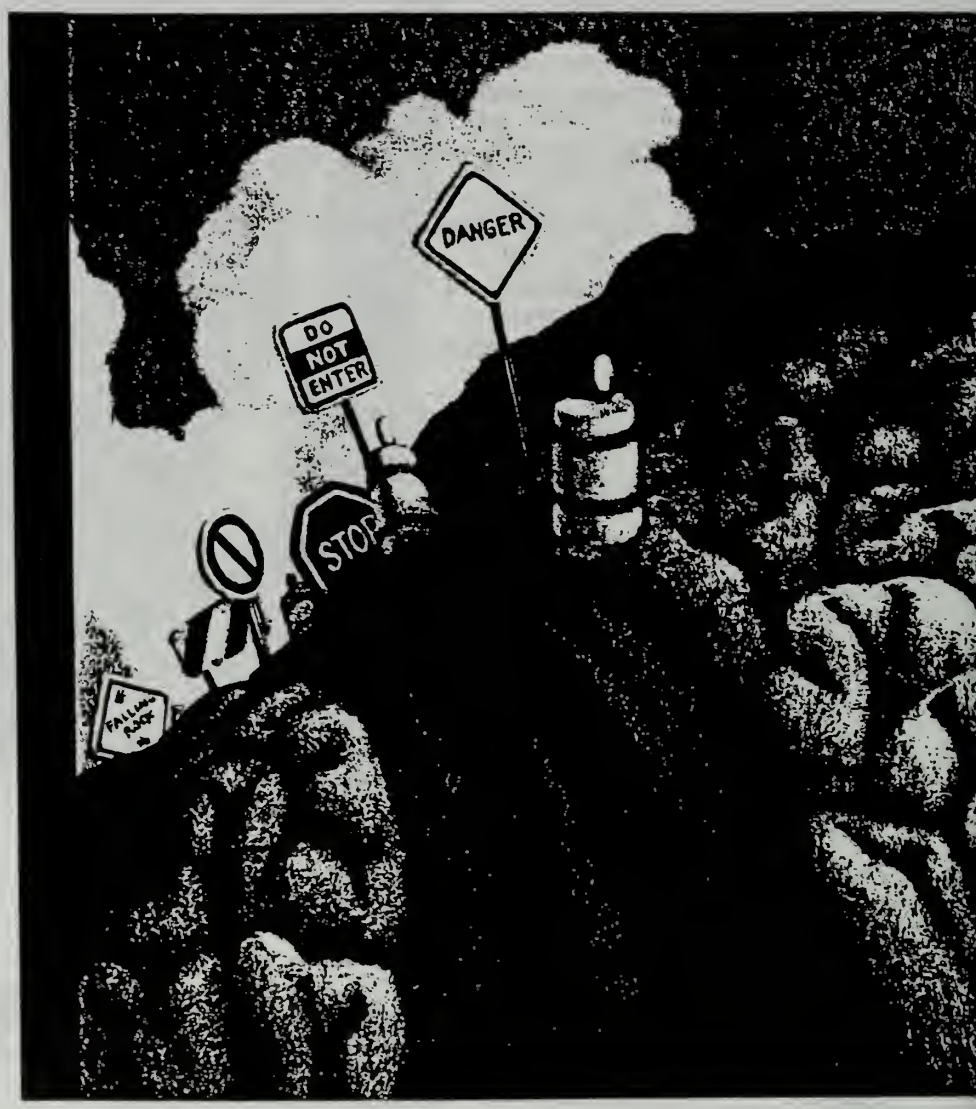
With these words, Susan's voice began to shake and she ducked her head, staring at the flowered pattern of the Kleenex in her fist. When she looked up, her eyes were narrowed and her face flushed a deep, mottled crimson. "You are so full of crap!" she spit out. "You're too weak to stand up to her, then you look at me as if *I'm* the one with the problem. God, what a sucker I am to stay with you!"

James rolled his eyes and sighed elaborately, then turned toward us. "You see what I have to deal with here?" he asked beseechingly. It was as though he had lit a match to his wife's innards. "Oh, that's good, James!" sneered Susan. "Blame me *again*! This is classic. You're such a fucking wimp!"

James didn't respond. In fact, I wasn't even sure he had heard her. His whole body seemed to contract as he turned toward the office picture window and stared unseeing through it, his mouth a taut line. Though he sat very still, I could hear the ragged sounds of his breathing. The relaxed, affable man who had entered our office 10 minutes earlier had simply vanished.

Looking back, I realize it was pure wishful thinking to equate this couple's initial good cheer with an easy session. In fact, over the years I have often been struck by how swiftly and dramatically the moods of intimate partners can change in the midst of an interaction, as though some internal switch gets flipped that compels each partner to react in a particular, almost predetermined way. In a previous session, James had jokingly called Susan "Sibyl," noting that whenever she became deeply upset, she entered "the zone," a place from which she could only react with white-hot wrath. At times, that rage turned physical: during one particularly savage fight, she knocked James unconscious by pushing him into a wall. Yet, in my observation, Susan was not the only partner prone to meteoric mood shifts. James's predictable response to Susan's rage—a lightning-fast retreat into his own zone of tuned-out, protective distance—was every bit as sudden and intense as his wife's.

Several years ago, we informally followed up with a number of our couples and found that within months of finishing therapy, many had reverted back to their old, well-honed tango of attack and withdraw, storm and stonewall. For some, it was as though they had never been in therapy at all.



In the past, the goal of our therapy with a couple like Susan and James would have been to teach them new habits of thinking and behaving that they could call into play whenever conflict arose. We would have coached them to listen to each other more attentively, fight more fairly, and give each other more benefit of the doubt. But over the years, we have noticed that the progress couples made in these areas tended to be disturbingly short lived.

Were we doing something wrong? My honest response is yes—and we have loads of company. Controlled studies of marital therapy outcome show that following a stint of treatment, only 50 percent of couples significantly improve. But even among those couples who do make progress, a big chunk—30 to 40 percent—relapse within two years. A close reading of this outcome research reveals a still more dispiriting reality: many of the

so-called "successful" couples reported still feeling unhappy with their marriages at a two-year follow-up. In the course of therapy, they had merely progressed from "highly distressed" to just plain "distressed."

Why are we doing such a lousy job of helping couples?

Numerous factors have been identified: couples come in too late to be helped; reimbursed sessions are too few; many clinicians are undertrained in marital therapy. But one possibility that we haven't yet confronted is that many of our most respected and widely used models for helping couples may be based on bad—or at least badly outdated—information.

Most couples therapy today is geared toward teaching partners to think and act differently toward each other, on the assumption that cognitive and behavioral strategies such as reframing, active listening, doing more of what works and so on can short-circuit explosive emotions and promote renewed intimacy and trust. But all of the foregoing assumes that our rational brains are in charge of our emotions, that what distinguishes Homo sapiens from so-called "lower" animals is our capacity to reason before we react.

But what if the human brain isn't actually wired that way? What if our neural circuitry programs us instead to rage and cower and collapse in grief in a nanosecond, before we ever get a chance to fashion an "I" statement or otherwise think things through? With the help of ever more refined imaging techniques that generate highly precise portraits of the brain in action, a new generation of neurobiologists is in the process of documenting that our cerebral topography actually favors flaming emotionality, not sweet reason. Thinking still counts, but not nearly as much as we've always assumed. So doctrine shattering is this mounting evidence for the hegemony of the "emotional brain," or more formally, the limbic brain, that Jaak Panksepp, a pioneering neurobiologist at Ohio's Bowling Green State University, has called it a genuine "neuroscience revolution."

But while the lay public appears fascinated by this new look at our emotional brains, catapulting books such as Daniel Goleman's *Emotional Intelligence* and Steven Pinker's *How the Mind Works* onto the bestseller lists, thus far, clinicians have seemed curiously unmoved. In our professional journals and conferences, we have done little grappling with the implications for psychotherapy of this major new strand of emotion research even though it strikes at the very marrow of the work we do.

Perhaps our field has hesitated to seriously confront the core tenets of the new, affective neuroscience because if we did, we might find out that we are heading down a hazardous road. For if our very brain circuits are primed to favor our most volatile emotions over reason, we may need to call into question our field's predominant tilt toward therapeutic models that rely on the sovereignty of rational thought to engender change. As economic pressures spur us to move increasingly toward ever briefer, more cognitive-oriented models, we may unwittingly be investing enormous energy in approaches that are, to a large extent, at odds with our brain's most fundamental functions.

Let me say clearly that at this juncture, almost nothing about the brain's role in emotion can be stated with absolute authority. Behavioral neuroscience is still an infant field, which means that many conclusions are still in the realm of correlation and possibility. And high-tech tools notwithstanding, the task of mapping the emotional brain is simply a staggeringly complex undertaking. Each human brain houses up to 100 billion neurons, each of which is capable of making, literally, thousands of connections with other neurons. Attempting to relate this intricate, electrochemical mesh to emotion, a concept that itself encompasses an enormously complex set of phenomena, is a truly daunting task.

Nonetheless, as the "black box" beneath our craniums is slowly and painstakingly being pried open, its contents deserve our close inspection. For while the latest findings about the primacy of emotions may be disquieting, they also hold the promise of more potent and effective ways of doing therapy. This new knowledge is already transforming my own work, spurring me to develop a clinical approach that empowers emotion and thought to work in common cause, rather than at cross-purposes, to help people manage their most volatile feelings. And whatever a therapist's current orientation—be it cognitive, behavioral, affective or some blend thereof—I believe that the newly charted links between our neural circuitry and our most primitive passions merit an open-minded and thoughtful response. For if we discover that we are, in fact, traveling down the wrong road, we will need to plot a powerful mid-course correction.

The amygdala, part of the limbic brain, has recently been identified as the brain's emotional alarm system. It scans incoming information for potential danger: *Is this bad? Could it hurt me?*

THE CONVENTIONAL VIEW OF HOW THE brain processes emotion is highly appealing to us humans, who love to fantasize that we're firmly in control. This comforting theory holds that information about the world is transmitted via our eyes, ears and other sensory organs to the thalamus, the brain's central relay station, which, in turn, ships it directly to the neocortex or "thinking brain." There, the incoming signals are efficiently recognized, sorted and assigned meaning, then ferried downstream to the limbic system or "emotional brain," which triggers the appropriate visceral response. In this tidy, reassuring scenario, emotion is the dutiful servant of the rational brain. Thought proposes, emotion disposes.

And much of the time, this is indeed how things work. But here's the catch: not *always*. Joseph LeDoux, a neuroscientist at the Center for Neural Science at New York University, recently discovered a second, parallel pathway that acts as a supersonic express route to the brain's emotional centers. This neural back alley, which appears to be reserved for emotional emergencies, bypasses the neocortex entirely, routing information from the thalamus directly to the amygdala, a tiny, almond-shaped structure in the limbic system that has recently been identified as the brain's emotional alarm center. The amygdala scans the information for potential danger: *Is this bad? Could it hurt me?*

If the information registers as dangerous, the amygdala broadcasts a distress signal to the entire brain, which, in turn, triggers a cascade of physiological responses—from a speeded-up heart rate to jacked-up blood pressure to mobilized muscles to the release of the "fight or flight" hormones, adrenaline and noradrenaline. Within milliseconds, we explode with rage or freeze in fear, well before our conscious mind can even grasp what is happening, much less persuade us to take a few deep breaths and maintain our cool.

This cranial takeover can occur because, neuroanatomically speaking, our thinking brain is simply outmatched by the competition. At the same time that emotion-laden signals are zooming down our neurological express route—what LeDoux calls the "low road"—the same data is being transported via the customary, well-trodden "high road" from thalamus to neocortex to amygdala. But because the shorter, subterranean pathway transmits signals twice as fast as the more circuitous route involving the neocortex, the thinking brain simply can't intervene in time. By the time the neocortex gets into the act, the damage has been done—you have already called your late-to-dinner partner an inconsiderate jerk, shrieked at your smart-mouthed child, snapped at your critical colleague or simply shut down, shaking inside, in the face of someone else's rage.

To make matters worse, by this time, amygdala-triggered emotional information has invaded the neocortex itself, overwhelming its centers for logic and judgment. As a result, your emotion-flooded thoughts about the situation are apt to feel entirely accurate and justifiable. Whaddya mean, I'm overreacting?

So much for the doctrine that rationality rules.

This telling new glimpse at the topography of the brain helps to explain those moments in the consulting room when you can see that couples are honestly struggling to think and behave differently, but simply can't make the shift. You watch your client trying to listen empathically to his wife, but when she lets him know that she is sick and tired of his shirking the housework, *bam*! Before you can say "reframe that thought," the amygdala is sounding its sirens and suddenly he's yelling that *she's* the slob, not him, in fact, she's let herself go big-time and is goddam *fat*! And as he's shouting all this, his face is turning the color of boiled lobster, his heart is practically leaping out of his chest and he is sweating gallons. Depending on your theoretical orientation, you might say this man had just contacted his "wounded child," or that he had been sabotaged by his "problem story" or that he was reenacting a hurtful, family-of-origin script. But at the level of brain wiring, his neocortex just got hijacked by his amygdala. And as we shall see, understanding this neural takeover isn't just some kind of intellectual exercise that explains our clients' reactivity: we can use it to help clients arm themselves against future cranial abductions.

Within milliseconds, we explode with rage or freeze in fear, well before our conscious mind can even grasp what is happening, much less persuade us to take a few deep breaths and maintain our cool.

But first, we need to understand a bit more about the tiny sliver of cerebral tissue that can so readily commandeer the brain—the amygdala. While neuroscientists are only just beginning to understand this complex little emotional sentry, they are reasonably certain that it is a major player in producing fear and anger, the particular kinds of emotions that frequently push people into therapists' offices. In one set of studies, when researchers implanted electrodes in individuals' brains and stimulated a particular circuit originating in the amygdala, subjects responded with heart-racing terror. When a different, amygdala-driven neural circuit was stimulated, individuals erupted in rage. In one study by Robert Heath of Tulane University School of Medicine, a man whose amygdala-based rage circuit had been stimulated furiously tore his hospital robe and lashed out at the physician who was standing nearby, threatening to kill him.

So much for lab-induced passions. But in our real lives, what makes our emotional brain kick into gear? Neuroscientists believe that in most instances, the amygdala makes its snap judgments based on the similarity of a current situation to past events that once enraged or terrified us. In short, the amygdala seems to be the repository of the very raw material of psychotherapy—emotional memory.

Until very recently, it was widely believed that the hippocampus, a seahorse-shaped structure in the limbic brain, was our emotional memory bank. But research by LeDoux and other neuroscientists now suggests that the hippocampus is actually more concerned with registering factual and contextual data, while the amygdala is the repository of primitive feelings linked with those facts and situations. So while the hippocampus will remember what your ex-partner looks like—the jerk who dumped you for a new lover—the amygdala is responsible for the surge of fury that floods your body when you see someone who looks even vaguely like your former mate.

And "vaguely" is the operative word here. For when the amygdala tries to judge whether a current situation is hazardous, it compares that situation with its motley collection of past emotionally charged events. If any key elements are even crudely similar—the sound of a voice, the expression on a face—it instantaneously unleashes its warning sirens and accompanying emotional explosion. No doubt, this quick-and-dirty assessment method had tremendous evolutionary utility. For our early ancestors, it was far better to react to a false alarm than to miss an underfed saber-toothed tiger lurking in the tall grasses.

But for modern-day relationships, the amygdala's penchant for sloppy generalizations can exact a steep price. To the amygdala, it may make no difference that it is your spouse who is angry with you and not your father, who regularly took out his wrath on your helpless body some 30 or 40 years ago. The emotional state triggered by the hypervigilant amygdala—shuddering fear or unholy rage—is apt to be exactly the same.

Back in our office, when Susan so suddenly turned on James, the volcanic eruption of her fury suggested to us that her amygdala had made some link between the triggering event—her perception that James had been disloyal to her—and a painful situation in her past. Years ago, we might have invested considerable energy trying to help her become aware of these early events, so that she could learn to disentangle them from her current interactions with her husband. But recent brain investigations suggest that in some cases, this kind of trolling for early trauma may simply be a well-meaning waste of time.

For while the amygdala is fully mature at birth, the hippocampus—our memory bank for factual data—doesn't fully develop until a child is at least 2 years old. This means that during early childhood, when relationships with caregivers have such profoundly life-shaping impact, the amygdala is busy making emotion-charged associations about events that the embryonic hippocampus never even records. An adult, then, can be plagued by chronic, debilitating emotional outbursts linked to a past event that he or she neither remembers nor has any way of recovering, since one cannot recover a memory that has never been recorded. Perhaps this is one reason why many clients seem so unwilling to relinquish their convictions that their explosive reactions to current spousal behavior—a wife's propensity to flirt at parties, a husband who forgets to call when he's going to be late—is entirely appropriate. There is no early memory, even a repressed, deeply buried one, to trace it back to.

But this bewildering amputation of emotion from its triggering event may take place at any point in our lives. Studies by Bruce McEwen, a researcher on the biology of stress at New York's Rockefeller University, indicate that even in a mature hippocampus, severe stress can cause a shriveling of dendrites, the stringy, branching ends of neurons that are largely responsible for the initial phases of long-term memory formation. Recent studies have shown that in trauma survivors, such as victims of chronic childhood abuse and Vietnam veterans with Post-Traumatic Stress Disorder, the hippocampus is measurably shrunken.

In stark contrast, stress seems to *enhance* the functioning of the amygdala. As blood levels of stress hormones shoot up, the amygdala seems to kick into overdrive, thereby facilitating extremely potent learned fear. So if a person endures a severely stressful situation, he or she may forget the distressing incident itself, yet become emotionally hyperactive to future events that are unconsciously reminiscent of the original, triggering situation. A client may have forgotten that she was raped repeatedly by her uncle, yet become panicky and tearful whenever her husband approaches her for sex. Or a man may verbally attack his wife whenever he perceives that she is being "distant" from him, having altogether forgotten that as a small child, his depressed mother regularly retreated to her locked bedroom, leaving him utterly alone for hours at a time.

THE IDEA THAT A PERSON'S CURRENT emotional reactions can be embedded in past events is nothing new—Freud figured that out long before the neurobiology techno-wizards arrived on the scene. But the gradually emerging portrait of our "emotional brain" gives us an illuminating window on why many clients find it so horrendously difficult to contain their reactivity in committed

love relationships. If the amygdala's original purpose was to act as our emergency alert system, leaping into action in response to life-or-death threats facing our ancestors, it is apt to activate with particular vigor in our intimate partnerships, which are so thoroughly tangled in primal need. Once, in our helpless infancy, our need to stave off abandonment truly was a matter of survival. So when our partner says or does something that telegraphs *This person doesn't love me! This person is leaving me!* our amygdala scrambles blindly, frantically to the rescue.

The central role of this hair-trigger brain mechanism in creating marital misery is persuasively suggested by the now famous "love lab" research of University of Washington psychologist John Gottman. By hooking up couples to a battery of physiological sensors while they discussed sensitive subjects, Gottman has documented that during highly toxic arguments, partners' bodies become flooded by a virtual tidal wave of brain-mediated bodily changes, including a quickened heart rate, stepped-up sweat production, tensed-up muscles and the release of a torrent of stress hormones. The split-second nature of these changes—an angry spouse's heart rate can accelerate 10 to 30 beats per minute in the space of a single heartbeat—strongly indicates a cranial coup d'etat originating in the amygdala.

And like most coups, this one can wreak ugly consequences. For Gottman further found that these classic bodily signs of an emotional hijacking were highly correlated with specific kinds of conflict behaviors—criticism, contempt, defensiveness, and stonewalling—that, in turn, strongly predicted later divorce. In his observation, the trajectory of divorce originates with frequent, nasty arguments that eventually cause both partners to develop a kind of bioemotional hypersensitivity to each other. In this state, observes Gottman, "you react to your spouse like an animal conditioned to fear a shock whenever it sees the color red."

In an ideal world, of course, couples would show up at a therapist's door long before this kind of knee-jerk hostility seeped into their marriage. Yet, research indicates that couples typically battle each other for a good six years before they finally find their way to a clinician's office. By this time, many couples have become so sensitized to each other that each partner may be only a spouse's caustic comment or dismissive glance away from an emotional mugging. In view of what we are learning about the hard-wired basis of these eruptions, it may be time to forthrightly confront our profession's gradual but unmistakable retreat from the whole arena of emotion. Might there by a link between our field's growing inattention to clients' internal emotional processes and our undeniably mediocre track record in helping couples?

There is little doubt that in psychotherapy today, the neocortex is where the action is. While a few emotion-centered approaches are still holding their own, they hardly represent the field's dominant direction. Instead, pressured by increasingly meager third-party reimbursements, clinicians have been scurrying to get trained in therapy models that promise the speediest possible results. And by and large, the briefest models tend to be those that zero in on retooling beliefs and behavior, based on the premise that changing thoughts and actions will, domino-style, cause feelings to change. In short, these models take for granted that the neocortex is firmly in charge of the limbic system.

And in some cases, they're right on target. Brain-mapping studies suggest that in emotion-tinged situations that aren't perceived as all-out emergencies, our thoughts do indeed play a central role in influencing feelings. If you are confronting a situation that is emotionally salient but not perceived by you as a life-or-death matter—let's say, you've noticed a worrisome drop-off in client hours—that information would travel first to the discerning neocortex, which would mull over the situation and decide on the appropriate emotional response.

If you were to apply a solution-focused approach to this matter, your neocortex might be enlisted to make a mental list of ways you've successfully beefed up your practice in the past and secure a commitment to try those strategies. A narrative model, meanwhile, might urge your thinking brain to coolly consider how Fear is trying to sabotage it. Within a traditional cognitive model, your neocortex might be encouraged to battle any rumination about imminent professional disaster with a tough-minded counterargument. Given the right conditions, each of these interventions would likely spur your rational brain to signal the amygdala to respond with, perhaps, mild anxiety leavened with a strong, motivating shot of hope. In short, when the neocortex has a chance to use its mus-

The trajectory of divorce originates with frequent, nasty arguments that eventually cause both partners to develop a kind of bioemotional hypersensitivity to each other, a condition that is called "chronic flooding."

cle, "think therapies" can be powerful agents of change.

The trouble is, of course, that the neocortex can be so swiftly hijacked. As we have seen, when we *do* deem a situation an emotional emergency, the amygdala lights up the entire brain and body with bioemotional fireworks before the neocortex ever gets into the act. It is in precisely these kinds of volatile, felt-crisis situations—which intimate partnerships, in particular, seem so readily to create—that thinking-brain therapies are at a serious disadvantage. Many clinicians, including myself, have spent untold sessions trying to get fuming couples to engage in some kind of well-established communications technique, such as "active listening," only to watch the whole thing fly apart when one partner says something seemingly reasonable—"I feel that the kids don't get enough of your attention"—which feels, to the other, like a poison arrow to the heart.

"Screw *that!*" the "listener" shrieks, whereupon the partner flings back that this is just so typical, isn't it, you're too narcissistic to even listen to me, always have been, what's the damn use? And in those moments, when your office is vibrating with fury and you feel more like a rookie referee at a mud-wrestling match than an authoritative, multidegreed professional, your bulging bag of reframings, restoryings and other sweet-reason techniques is worse than useless. Sweet reason just got clobbered. The amygdala is king.

So where does this bad-news tale of limbic mayhem leave therapists? If an element of our humanity as unalterable as brain architecture favors blind emotion over rationality, why even bother to try to help clients master their most volatile and disabling reactions? In my experience, this work remains not only critical, but eminently possible. For while the amygdala may run the neural show at times, it is by no means an entrenched, power-mad despot. Instead, I have found it to behave more like an overprotective parent who, if approached in the right way, can be persuaded to relax its nervous grip on its child.

This neural "relaxation response" is possible because it turns out that our brains are wired not only for defense, but also for connection. In a related and far more heartening realm of neuroscience, researchers have begun to chart paths for a number of discrete brain circuits that reliably activate specific emotions, along with associated thoughts and behaviors. While circuits for fear and rage have been most thoroughly mapped thus far, the neurological terrain of intimacy-arousing emotions—most notably sorrow and nurture—have very recently been identified.

Electrically stimulate an individual's sorrow circuit, researchers have found, and that person will report feeling sad or lonely and express the need for comfort. Activate the nurture pathway, and an individual will experience a surge of tender, generous feelings and voice the urge to care for someone. When I first encountered this realm of research, I felt a ripple of hope: Perhaps there was some way to help clients move from a connection-breaking circuit, such as fear or anger, to one that promoted emotional vulnerability and intimacy. But how?

As I was trying to penetrate this puzzle, I recalled perusing recent research by University of Wisconsin psychologist Richard Davidson that suggested that the left prefrontal lobes, the wedge of neocortex located just behind the forehead, played a critical role in moderating emotional reactivity. While it appeared that this sector of the brain could not keep the amygdala from spazzing out in the first place, in some cases it seemed able to reduce the longevity and intensity of neural hijackings and thereby to limit the fallout.

This made sense to me: It seemed all but inevitable that we would need to use a slice of our orderly neocortex to guide us out of the emotional swamps. Yet, both my clinical experience and my growing familiarity with the workings of the brain told me that in the grip of a "survival" emotion, clients could rarely simply think themselves into a more tranquil state. Then, suddenly, I was struck by one of those unbidden, "aha" experiences.

It occurred to me that if the amygdala is, indeed, a vestige of our primeval survival arsenal, perhaps it will not—simply *cannot*—quiet its wailing sirens until it gets a clear signal that its urgent, life-preserving clamor has been heard. This would explain why new cognitions or behaviors are rarely sufficient to influence "emergency" emotional situations, for those interventions seek to override, rather than attend to, the amygdala's frantic distress calls. But what might happen instead, I wondered, if we helped our clients use their rational brains to fully acknowledge and soothe their primordial limbic systems?

From this core idea, I have developed a clinical model that puts the thinking brain unreservedly at the service of the emotional brain. The goal of this approach, which I call Pragmatic-Experiential Therapy, is to help clients shift from the defensive, isolating brain circuits that control rage and fear to the connecting, healing circuits that mediate nurture and sorrow. Giving immediate and thorough attention to clients' up-and-running, defensive neural systems, we coach clients to sympathetically and respectfully interact with those brain states until they feel safe enough to switch to more vulnerable states.

In our experience, this internal sense of safety is the linchpin of change for couples. For only when an individual feels no longer threatened by his or her partner—threatened, at bottom, by the terrifying, annihilating prospect of abandonment—will the amygdala shut off its internal alarm system, freeing the individual to authentically shift to an intimacy-promoting neural state. So, unlike therapeutic models that zero in immediately on changing thinking or behavior, we don't ask clients to change how they think about, or behave with, their partners until they *feel* safe enough to interact in a more vulnerable way.

This is not to suggest that cognitive and behavioral strategies are unimportant to effective therapy. In our clinical work, the rational brain—particularly the prefrontal cortex—is an absolutely central player. The key difference between our approach and explicitly cognitive models is that rather than using the thinking brain to try to dominate the emotional brain, we put it to work helping the ancient amygdala to gradually relax its defenses. To do anything less, we believe, is to paddle against our neural currents.

As Lisa and I sat with James and Susan in our consulting room, we well knew that "helping the amygdala to relax" was the last thing they had in mind. What was clear, however, was that each partner was far too stuck in his or her respective emotional circuit—Susan in rage, James in fear—to make any immediate shift to a more intimacy-promoting state. Before that could happen, each partner would need to get on much better terms with the feelings that had so violently seized him or her. We responded, therefore, as we customarily do when couples encounter extremely "hot" emotional states—by calling a temporary time-out on conjoint work to conduct some one-on-one emotional exploration.

Leaving Lisa and Susan to work together in our office, I asked James to join me in a consulting room down the hall. There, I suggested that if he was willing to explore his inner experience a bit, he might be able to learn to respond to Susan in a way that helped her to treat *him* well in return. He agreed to try, warning me, however, that self-awareness wasn't his "thing." Like many men I work with, James had done a good job of numbing his body to the telltale, physiological signs of an emotional hijacking—the knotted muscles, the racing heart, the queasy stomach—and consequently, during his fights with Susan, he often had trouble knowing what he felt at all. His lifelong stance, he admitted, was to keep a "stiff upper lip" in the face of trouble—he saw no other options.

"None?" I inquired. "Who taught you that?" After a few moments of silence,

The amygdala is an outrageously ineffective protector. Churning out white-hot emotions in the absence of tempering thought, it transforms us into 2-year-old tantrum throwers and scaredy cats, all but guaranteeing the opposite of the loving care we crave.

he began to talk of his junior high football coach, whom he remembered as single-mindedly intent on forcing him and his teammates to perform endless calisthenics until their bodies screamed for relief. The coach would then stride up to the player with the most tortured expression, get right in his face and shout: "What do you *feel?*" On cue, the player would yell back: "*Nothing*, sir!" to the loud cheers of his teammates. On one broiling afternoon on the football field, James heard those rousing cheers for himself, and he recalled now how curiously proud he felt of his stoic denial of his own body. Shaking his head, he admitted: "I guess I learned the lesson well."

I assured him it that would be possible—necessary, in fact—to relearn to recognize his feelings. In an important way, I explained, the body was the voice of the emotions, eloquently communicating critical information about our current emotional state. Tightened muscles and a sick sensation in the gut, for example, typically accompany fear, while rage is characterized by an upsurge in aggressive energy and increased body temperature. Learning to readily identify an "emergency" brain state via its characteristic physiological signals is the first, crucial step of our approach, because brain studies suggest that the moment you become aware of your internal state, you activate the prefrontal lobes, which, in turn, can begin to moderate your response. I suggested to James that the next time he and Susan begin arguing, he simply try to notice any changes happening in his body.

At the next session, Susan and James came—or rather stalked—into our office, their signature brain states already activated. Susan was furious at James for forgetting to buy her flowers for their anniversary; James, already withdrawn, slumped sullenly into his corner of the sofa. As soon as Lisa and I got the gist of their current conflict, James and I took off again for a private tête-à-tête.

Before I had even closed the door behind us, James reported that he was feeling an uncomfortable tightness both in his stomach and his lower jaw, sensations he had noticed several times over the past week whenever Susan had become angry with him. At my suggestion, he checked his current pulse rate and was stunned to find it had soared to 85 beats per minute, in contrast to his usual, resting rate of 68 bpm. In fact, this dramatic jump in heart rate closely mirrors that of experimental animals in the "freeze" state after their fear systems have been electrically stimulated. James, whose clenched-jaw, stonewalling response to Susan's fury had a distinctly frozen quality, was clearly in the midst of a full-fledged, brain-mediated fear response.

I encouraged him to notice how his state of mind seemed to kick in all at once, as if a part of him just stepped forward and took over. He replied that he had already noticed this happening a few days earlier, when Susan was ragging at him about the state of their finances. "I actually tried to respond to her, you know, say something sympathetic about the bad day I knew she'd had," he reported. "But somewhere inside, I'd just gone cold." I suggested that he might think of that frozen, steely part of himself as a little guy within him whose job it was to defend him against Susan's attacks.

In our experience, personalizing emotional states is a powerful way of helping people to accept their survival-driven emotions, which prepares them to interact respectfully with them. For this personalizing strategy, we are indebted to Dick Schwartz's Internal Family Systems model, which conceptualizes conflicting behaviors as inner family members, each with its own distinctive personality and function. In our work, we personalize particular bodily responses, such as a constricted throat or a nauseated stomach, that correspond to a client's emotional state. While I was encouraging James to view his knotted stomach as a difficult but fanatically loyal friend, Lisa, two doors down the hall, was similarly helping Susan to understand her rage response—particularly a characteristic throbbing sensation behind her temples—as a desperate, love-hungry little kid inside her who was frantically trying to get her husband's attention. The next step would be to help each of them consult with these inner defenders about the possibility of letting down their respective guards.

At this point, proponents of systems therapy may well be raising their collective eyebrows, thinking: This is *couples* work? My response is that while we do a lot of individual work with intimate partners, we are very definitely doing couples therapy. In our experience, the hair-trigger defense system of the emotional brain is such that for many couples, learning to regulate brain states is all but impossible in each other's presence; nobody can calm down long enough to do the kind of quiet, deeply focused work that is necessary to allow an emotional system to shift. Particularly early in therapy, each partner is far more likely to chronically trigger the other's already hyperaroused limbic system than help to soothe it, a pattern that may lead many couples to prematurely quit therapy, convinced that theirs is a "hopeless case."

Consequently, our customary modus operandi is to do a lot of individual work during the first several sessions, until each partner develops enough skill in shifting brain states to rejoin his or her partner in the consulting room. At that point, couples begin to practice making these shifts in "real time," in the midst of authentic interactions. In this way, work on the internal system of brain states powerfully supports work on the external system of a relationship in action.

Over the next several sessions, Lisa and I stepped up our roles as personal coaches, helping Susan and James learn to shift their self-protective brain states to those mediating nurture and sorrow. We knew that when the sorrow neural system is electrically stimulated in animals, they emit distress vocalizations signaling a kind of mammalian separation anxiety, which, in turn, triggers a "moving toward" response from nearby animals. This is, of course, the same primal dance we endlessly try to choreograph in our therapy offices: if he would only drop his Lone Ranger mask, we would bet the rent that she would reach out to him. The catch, of course, is that nobody wants to go first. By being more aware of the conditions that allow the brain to relax sufficiently its defenses, we hope to more effectively support our clients in making this leap out of fear and into connection.

To that end, I spent several sessions coaching James through conversations with his stonewalling "defender," in an effort to help it to feel safe enough to let down its guard. Progress was gradual and halting. Then, toward the end of one particularly slow-moving session, I brought up how James's typical response to Susan—sullen stonewalling—had not managed to blunt her fury so far. He nodded, admitting that, in fact, his icy withdrawal seemed to aggravate his wife even more. I suggested that James notice how his inner sentry reacted when I asked: "What have you got to lose by trying something new—like reaching out to Susan?" This was a delicate moment: I was asking James to engage his prefrontal cortex to entertain a new thought, without asking him to willfully redirect his current thinking. His hand on his stomach, James closed his eyes and focused his attention within. Perhaps 15 seconds passed before he opened his eyes and looked at me. "It's okay," he softly said.

"You're sure it's okay with him?" I asked, pointing in the direction of his stomach. "Yeah, he's okay," nodded James. He looked relaxed and younger, somehow—less defended. His inner watchdog, he told me, had acknowledged that shutting down had only gotten him a redoubled dose of Susan's rage, the terrifying experience of all-out attack that had activated his defense system in the first place. If there were a better way to stave off these assaults, his defender told him, it would do its best to stand aside. "I'm ready," James said quietly.

Susan was on her way to being ready, too. While James and I had been doing our work, Lisa and Susan had been making steady progress in helping Susan's inner defender feel safe enough to expose the intense yearning for love that hid behind her fury. As each partner's neural defense system gradually relaxed its hold, we began spending less time on one-on-one coaching and more time in conjoint sessions, helping them to practice real-world interactions without flipping into their respective fury and fear states.

Then one evening, Susan and James walked into our office in utter silence. They had had a violent argument two days before and had barely spoken to each other since. The issue at hand was James's relationship with his younger brother, Sam, and his sister-in-law, Claire, who lived only a few streets away from them. Susan had long felt resentful toward Sam, whom she felt took advantage of James's helpful nature, but even more hostile toward Claire, a stunningly beautiful local fashion model. James denied feeling attracted to Claire, but Susan had not believed him since the night she had seen James flipping through the pages of her modeling portfolio, which included some nude pictures.

Susan was furious now because, on the first day of a recent, heavy snowstorm, James had called to say he was stopping on his way home from work to help Sam and Claire dig out their driveway before coming home to help Susan shovel out so she could attend an evening yoga class. An hour later, when Susan walked the half-mile to her in-laws' house to drag her husband home, she was incensed to find James and Claire working in the driveway and laughing companionably together, with Sam nowhere in sight. That evening, Susan never made it to her yoga class; instead, she raged hard and long at James, accusing him of caring more about his brother's long-legged, exotic-looking wife than about her.

As our session began, Susan warned that this was a horribly painful issue for her. As she began to recount the incident, within seconds she was breathing so hard and fast that I thought she might start hyperventilat-

ing. "James," she managed between jagged breaths, "do you have any clue what you're like when you get within sniffing distance of Claire?"

I quickly looked at James, who had turned his gaze downward and was sitting stock-still. I feared he was shifting into a full-scale shutdown. But after a long moment he looked up again at his wife. "Susan," he began softly, "I don't give a damn about Claire." When Susan hooted bitterly at this, James shook his head in frustration. But he didn't fold. "When Sam called me to help out, I just didn't think," he went on. "I should have."

When Susan turned away in disgust, James looked suddenly desperate. "Look, Susan," he said pleadingly, "when you get mad at me like this, it's awful." She looked back at him, clearly surprised. "It makes me feel sick inside," he admitted to her. "I feel kind of lost." As Susan continued gazing at him, he touched her arm. "But whatever I did, I'm sorry I hurt you."

At this, Susan's face began to crumple. "You *did* hurt me, James," she cried out. Tears spilling down her cheeks, she jumped up and fled the room. For a moment, James looked stunned and disoriented: A tearful Susan was not what he had expected. Then he, too, abruptly rushed out into the hallway, where his wife was weeping. "God, Susan, I really didn't know what a big deal this was to you," we could hear him say. "Will you help me understand?" As she continued to sob, we stepped out into the hall in time to witness James enveloping his wife in a bear hug and whispering into her hair: "It's you I want."

It was a moment of great tenderness, one of those exchanges of naked need and open-hearted nurture that remind a couples therapist why he or she has chosen this work. Yet ultimately, the melting moment of bonding that we had just witnessed was not what made us feel optimistic about James and Susan's future. For we knew that such jolting shots of connectedness, however real and deep, would inevitably fade; stinging disappointments and misunderstandings would arise again. What encouraged us most was that in the midst of this highly charged interaction, James had demonstrated the ability to shift from a reaction of fearful withdrawal to a warmly empathic state that, in turn, allowed Susan to shift from her own state of fury to one of sorrowful hurt. We knew that if they were to construct an intimate bond that could truly sustain them—and not remain on a neural roller coaster of endless highs and lows—they would need to continue the difficult and delicate work they had begun. Little by little, they were teaching their brains to trust.

This is the same primal dance we endlessly try to choreograph in our therapy offices: If he would only drop his Lone Ranger mask, she will reach out to him. The catch is that nobody wants to go first.

To imagine ourselves this way—as beings whose deepest passions are rooted in the pushing and pulling of neurons along the electrochemical tracks of our brains—is, at best, a disturbing experience. To therapists, especially, all this talk of neural circuitry and amygdalian imperatives may seem distastefully cold and mechanistic for a phenomenon as warm-blooded and mysterious, even sacred, as emotion. Yet, what may be finally most disquieting about this exploration of the emotional brain is not that it separates us from the pulsing core of our feeling selves, but rather that it brings us so uncomfortably close. Any serious examination of the ancient, neural bases of emotion forces us to confront our essential kinship with other mammals—those instinctual beasts who seem all bared tooth and bloody claw, so fundamentally different from our proudly cerebral human selves.

We get ourselves into far more trouble than it's worth, suggests neurobiologist Jaak Panksepp in his groundbreaking book *Affective Neuroscience*, through "our strangely human need to aspire to be more than we are—to feel closer to the angels than to other animals." So deeply uneasy are we with the quivering, feral forces that can, in an eye-blink, burst through our surfaces that we risk encasing ourselves in a kind of protective cognitive supremacy, identifying much too thoroughly with our city-building, bookwriting, resolutely right-minded selves. Of course, our rational brains are potent, indispensable human equipment. But the paradox is that these impressive cerebral capacities can only guide us to safety if we acknowledge and honor, too, the primeval responses that still lurk in the lattices of our neural wiring. Far from dehumanizing us, they are the elements of our humanity that we most urgently need to welcome. ■

Brent Atkinson, Ph.D., is director of the family therapy program at Northern Illinois University and is in private practice in Geneva, Illinois. Address: School of FCNS, Northern Illinois University, DeKalb, IL 60115; e-mail address: bja@niu.edu

Section E:
Beyond Victimization: Ways of Healing

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Panelists:

Kathleen O'Neill Alexander
Director of Education & Outreach
District Attorney's Office
1 Gleason Place
Northampton, MA 01060
(413) 586-5780
Email: Kathleen.O.Alexander@state.ma.us

Deb Brunet
A survivor of violent crime
c/o MOVA
1 Ashburton Place, Suite 1101
Boston, MA 02108
(617) 727-5200

Robin Casarjian
Executive Director
The Lionheart Foundation
Box 194 Back Bay
Boston, MA 02117
(617) 267-3121

Richard Hoffman
3 Gladstone Street
Cambridge, MA 02140
Email: rhoffman@frontlinepub.com

Coordinator: **Lynne Williams**

Finding New Life After Columbine

A year after the massacre, some parents are trying to find peace by joining in a war against school violence

BY ANDREW MURR

DANIEL MAUSER, ISAIAH SHOELS and Craig Scott were studying in the Columbine High School library last April 20 when the shooting began. Dylan Klebold and Eric Harris burst through the doors and opened fire. When the killers ran out, Daniel and Isaiah were dead. Their friend Craig survived by pretending to be dead himself; but his older sister Rachel was killed fleeing from the cafeteria.

In the year since Harris and Klebold took the lives of 12 students and a teacher at Columbine High, the families of the victims have begun to emerge from the shock of their terrible grief. Many of the families have pulled together to form a quiet support network, meeting monthly for potluck dinners. They've united in a cause, raising $3.1 million to replace the school's bullet-pocked library. Yet in private, each family has been left to answer the question that Daniel Mauser's father, Tom, says ate at him in the weeks after the shooting: "How are you going to get on with your life?"

The parents of Daniel Mauser, Rachel Scott and Isaiah Shoels have each taken on very different but very public roles as activists against school violence. Like most of the parents, Tom Mauser lived in a daze for weeks after his son, Daniel, was killed. "It was a hell, a living hell," he says, the emotion still fresh in his voice. His mind began to clear with a memory of a conversation he had with Daniel two weeks before his death. At the dinner table one night, Daniel began talking about gun control, a topic no one in the family had paid much mind to. "Did you know there are loopholes in the Brady bill?" he asked. Tom Mauser remembered his son's question when he learned that the National Rifle Association was planning to hold its annual convention in Denver last May, just days after the shootings. Mauser attended a protest rally at the state capitol, where he spoke movingly to the crowd of 8,000.

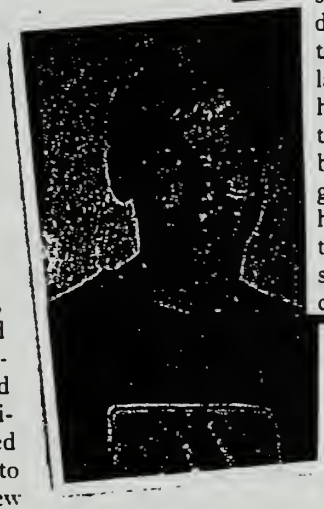
Last January he took a leave from his job as a mass-transit planner and dedicated himself to reforming the state's gun laws. He gives speeches, lobbies Colorado's politicians and visited with President Clinton, who pointed him out at January's State of the Union speech. (This week Clinton will travel to Colorado to lend support to a gun-control ballot initiative Mauser is pushing.) Mauser says he will return to his job next year, and hopes life will settle down for him and his wife, Linda, and their 14-year-old daughter, Christie. She'll enter high school next year—but not, her dad says, at Columbine.

Rachel Scott's family found comfort in other ways. A few weeks after her death, the family discovered a set of diaries and journals the 17-year-old had kept. Many of the diary entries described Rachel's commitment to God. Her family knew she was a compassionate girl who tried to practice what she called "acts of kindness," but they did not realize how spiritual she had become. "I've seen a whole new side of Rachel that's absolutely precious and wonderful," says her mother, Beth Nimmo.

Rachel's father, Darrell Scott, left his job as a sales manager and began touring the country speaking to church groups, hoping to "help people see that this event did have a spiritual side," he says. Though he's not against gun control, he believes "We are slapping Band-Aids on deep gaping wounds when we simply look at the weapons that were used instead of the reason why the boys were motivated to kill."

Like Darrell Scott and Tom Mauser, Michael Shoels is on a mission to make sense of his son's death. But unlike them, he has yet to find much peace. Isaiah Shoels was the only black student killed at Columbine. Eyewitnesses said that Harris and Klebold came into the library looking for "that little n-----." To Michael Shoels, his son's murder was clearly a hate crime. In the weeks after the shooting, Shoels demanded a federal investigation and filed a $250 million lawsuit against the families of the two killers. Shoels charged that the community and the school fostered a racist environment, looking the other way when black students were harassed. Some whites in the community branded Shoels as opportunistic and greedy. He had difficulty sustaining his business as an independent music producer, and the family, feeling unwelcome, moved to Texas.

These days Shoels travels the country speaking out against violence. He says he doesn't accept money for his appearances, though some audiences pass the hat. The lawsuit wasn't about the money, he insists: he just wanted to get people to pay attention, to admit that the roots of the Columbine murders run deeper than a failure of gun control. Pounding the kitchen table in his suburban home in Katy, west of Houston, he says, "Everybody in Colorado is in a state of denial. We all know it was a hate crime. Why won't people admit it?"



'It was a hell': *Tom Mause lived in a daze until he cho to honor his son, Daniel, b fighting for gun control*

The coming anniversary seems to be a focal point for the families. Many will participate in memorial services to be held in the park behind the high school. Tom Mauser and his wife, Linda, hope to adopt a Chinese baby this fall. The Shoels, settled in Texas, plan to buy a home; Michael is producing a memorial CD in his son's honor. After a painful year of looking back at tragedy, the families of Columbine are beginning to look forward with hope. ■

"We are slapping Band-Aids on deep gaping wounds when we look at the weapons that were used instead of why the boys were motivated to kill." —DARRELL SCOTT, *father of a victim*

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BYLINE: By Richard Hoffman

BODY:

My 10-year-old daughter brought us the news. She told of a little boy across town who had been kidnapped, raped, and killed. She insisted I turn on the TV to find out more. I hesitated, wanting to protect her, as if protecting her from the truth was the same as protecting her from evil. I turned on the news.

Mostly I was concerned for my daughter's feelings. But as a parent, my heart also ached for the parents of this boy whose name we did not yet know. And as a man who was raped at age 10 by a coach who, before he was stopped, went on to devastate the lives of hundreds of children, I felt an old rage surface again.

Soon we learned the boy's name was Jeffrey Curley.

Because of my own history, I have been trying to understand the enormity of this evil for a long time now. I have come to few conclusions except that we have to begin with a different set of terms if we are to avoid the same fear, helplessness, and despair that have incapacitated us and continue to place children at risk.

We have been misled by the language we use, by the way we talk about those who would harm our children. Our words are important. Words are how we think. We talk of them as "sick." We use names that accept their denial and distortion. We become tangled in language that does not reflect reality but hides it until, over and over, child after child, it is too late.

Let's begin by refusing to use the word "**pedophile.**" The word comes from Greek and means, literally, "one who loves children." What an Orwellian inversion. To use this word to describe those who violate children and in many instances kill to silence them is to help the wolf into his woolly disguise.

The term **pedophile** is more than a poor word choice, however; a pseudo-medical term, it asks us to see such evil as arising from disease or illness, evil in its effect, perhaps, but no more intentional than other natural misfortunes like diabetes, say, or muscular dystrophy. This makes the violation of children a part of the natural order and the perpetrator one who cannot help himself.

In place of "**pedophile,**" then, let me offer an alternative: pedoscele, from Latin "scelus," meaning "evil deed." Try it. Ped-o-skeel: one who does evil to children.

And let's stop calling them "sex offenders," as if their crimes had anything to do with sex. As the

poet Linda McCarriston once pointed out, "Saying the man had sex with the child is like saying the man had dinner with the pork chop."

The rape of a child is a violent act of contempt, not an expression of sexuality or affection. Pedosceles want us to believe otherwise. This is why they talk of "love" between men and boys. All too often we fall for it.

A couple of years ago, a pedoscele named Thomas Hamilton massacred a kindergarten class in Dunblane, Scotland. He had driven, unwelcome, from one community to another for decades, but police were not able to find parents unashamed to take a case to court. Instead, he was shooed along, referred to as a "misfit," and became, each time, the next community's problem.

The subsequent slaughter, like the murder of Jeffrey Curley, unmasks the real nature of this type of child abuse. At its core is a hatred of that naivete and vulnerability we call innocence. The murderers of Jeffrey Curley could not stand that quality, and they killed the child who represented it.

While we're at it, let's retire the word "molest." On a recent family trip to a bird sanctuary, we observed signs that read: "Do not molest the birds." Look it up. Molest means to bother. Bother? Excuse me, sir, you're bothering my child.

Even speaking informally we communicate mostly ignorance, discomfort, and confusion. I have heard the word "diddle" used to describe (and dismiss) the violation of children, as in "he likes to diddle little boys." It is a word that seems made to order, silly sounding, sniggering, naughty. Diddling, fondling, fooling around - great foggy euphemisms into which real children like Jeffrey Curley vanish.

We need to create safety for our children. But the first step in doing so is to see reality clearly. By using language that reflects the true nature of the crimes committed against children, maybe we can figure out how to protect them from people who hate them for being what they are: young, trusting and innocent.

MESSENGERS

"The house itself, if it had a voice,
would speak out clearly. As for me,
I speak to those who understand:
if they fail, memories are nothing."

Aeschylus: *Agamenmnon*

We say what we know because we must.
You can cheer us or run us out of town.
It's nothing at first, like rain on dust,

a hairline crack in the faultline's crust,
a tentative first-person plural pronoun.
We say what we know because we must

recall, recount, redeem, and readjust
all that we've known, not for renown.
It's nothing at first, like rain on dust,

or the first few tiny flecks or rust
on barrels buried underground.
We say what we know because we must

talk back to histories we do not trust,
relearn our own, and set them down.
It's nothing at first like rain on dust.

What does it mean to fear what's just?
You can cheer us or run us out of town.
We say what we know because we must.
It's nothing at first, like rain on dust.

Richard Hoffman, 1999

Spirituality as a Tool for Healing

Prepared by Kathleen Alexander
Office of Northwestern District Attorney
Elizabeth D. Scheibel

SPIRITUALITY AND HEALING

• Every moment is the right moment to begin. Jonathan Schell

• Knock on yourself as upon a door
and walk upon yourself as on a straight road.
For if you walk on the road,
It is impossible for you to go astray.
And if you knock with wisdom,
You knock on hidden treasures...
Wisdom is a holy kingdom and a shining robe. Teaching of Silvanus

• There is a DREAM
dreaming us. African Bushman

• Your own Self-Realization is the greatest service you can render the world.
Sri Ramana Maharshi

•Therefore, Anada, be ye lamps unto yourselves, be ye a refuge to yourselves. Betake yourselves to no external refuge. Hold fast to the Truth as a lamp; hold fast to Truth as a refuge. Look not for a refuge in anyone beside yourselves. The Buddha

• The purest acts of worship acknowledging her presence within us are the simple significant gestures toward the natural objects outside us - touching a stone or a tree, drinking water and milk, being with fire or standing in the wind or listening to birds.
Meinrad Craighead

• When sleeping women wake, mountains move. Chinese Proverbs

• For each of us as women, there is a deep peace within, where hidden and growing our true spirit rises... Within these deep places, each one holds an incredible reserve of creativity and power, of unexamined and unrecorded emotion and feeling. The woman's place of power within each of us is neither white nor surface; it is dark, it is ancient, and it is deep. Audre Lord

• Treasures of revelation emerge from the Mother ocean...
Dive with abandon into her mystery.
You will discover a new gem every moment. Ramprassad

• Believe nothing because a wise man said it,
Believe nothing because it is generally held.
Believe nothing because it is written.
Believe nothing because it is said to be divine.
Believe nothing because someone else believe it.
But believe only what you yourself judge to be true. The Buddha

•.When you are intoxicated with divine love, you see God in all beings.
The Gospel of Ramakrishna Sri Ramakrishna

• I think it pisses God off if you walk by the color purple in a field somewhere and don't notice it. Alice Walker

• The entire world is being driven insane by this single phrase:
'My religion alone is true' Ramakrishna

• When the moon rises in the Heart of Heaven and a light breeze touches the mirror - like surface of the lake,
That is indeed a moment of pure joy
But few are they who are aware of it. Taoist Sage

•Because we have heard and because faith tells us so, we know we have souls. But we seldom consider e precious things that can be found in this soul, or who dwells within it, or its highest value.
The Interior Castle St. Theresa of Avila

THE GOD WITHIN

• I believe that God is in me as the sun is in the colour and fragrance of a flower- the Light in my darkness, the Voice in my Silence. Helen Keller

• I am closer to you than yourself,
Than your soul, than your own breath.
Why do you not see me?
Why do you not hear me? IBN AL ARABI

• I am thou and thou art I: and wheresoever thou art I am there, and I am sown in all; from whencesoever thou willest thou gatherest Me; and gathering Me thou gatherest thyself.
The Gospel of Eve

• This Self is the honey of all beings and all beings are the honey of this Self.
Brhadaranyaka Upanishad

• He that dwelleth in the secret place of the most High shall abide under the shadow of the Almighty.
Psalm 91

• I am a lamp to you who behold Me
I am a mirror to you who perceive Me
I am a door to you who knock at Me
I am a way to you, a wayfarer.
You have Me for a couch; rest then upon Me. The Acts of John

• Look upon a woman as a goddess whose special energy she is, and honor her in that state. Uttara Tantra

• God wants the heart. Talmud

• The image of God is found essentially and personally in all mankind. Each possesses it whole, entire and undivided, and all together not more than one alone. In this way we are all one, intimately united in our eternal image, which is the image of God and the source in us of all our life.
The Adornment of the Spiritual Marriage Jan Van Ruysbroeck

• O Greening Branch
You stand in your nobility
Like the rising dawn
Rejoice now and exalt
And deign to free the fools we are
From our long slavery to evil
And hold out your hand
To raise us up. Hildegarde of Bingen

•The eye with which I see God is the same as that with which he sees me. My eye and the eye of God are one eye, one vision, one knowledge, and one love.
Meister Eckhart

• God does not proclaim Himself. He is everybody's secret. Katha Upanishad

• For everything that lives is holy. William Blake

• Each bush and oak know that I AM. Henry Vaughan

• Holy Mother Earth, the tree and all nature, are witnesses to your thoughts and deeds.
A Winnebago Wise Saying

• I live my life in growing orbits which move out over the things of the world.
And I have been circling for a thousand years
And I still don't know if I'm a falcon, or a storm, or a great song.
Rainer Maria Rilke

• I am certain of nothing but the holiness of the Heart's affections and the truth of Imagination. What the imagination seizes as Beauty must be truth.
Letters John Keats

• Rise up, my love, my fair one, and come away
For lo, the winter is past the rain is over and gone:
The flowers appear on the earth;
the time of the singing of birds is come,
And the voice of the turtle is heard in our land;
The fig tree putteth forth her green figs,
and the vines with the tender grapes give a good smell.
Arise, my love, my fair one, and come away.
Song of Songs 2:10-13

SPIRITUAL PRACTICE

• Righteousness, and sacred learning and teaching
Truth, and sacred learning and teaching
Meditation, and sacred learning and teaching
Self-control, and sacred learning and teaching
Peace, and sacred learning and teaching
Ritual, and sacred learning and teaching
Humanity, and sacred learning and teaching
Taittirya Upanishad

• I listen and her the Silence
I listen and see the Silence
I listen and taste the Silence
I listen and smell the Silence
I listen and embrace the Silence Twylah Nitsch

• Place your mind before the mirror of eternity!
Place your soul in the brilliance of glory!
Place your heart in the figure of divine substance!
And transform your entire being into the image of the Godhead Itself through contemplation. Saint Claire of Assisi

• Each creature God made
Must live in its own nature
How could I resist my nature
That lives for oneness with God?
The Flowing Light of the Godhead
Mechthild of Madeburg

• Focusing one's mind on one's partner and nurturing the relationship are at the heart of conscious loving." Caroline Muir

• True prayer and love are really learned in the hour when prayer becomes impossible and your heart turns to stone.

• Grandmother consciousness opens a woman to images of the past, to the face of the future, and to the symbolic pattern of a woman's life.
Naomi Ruth Lowinsky

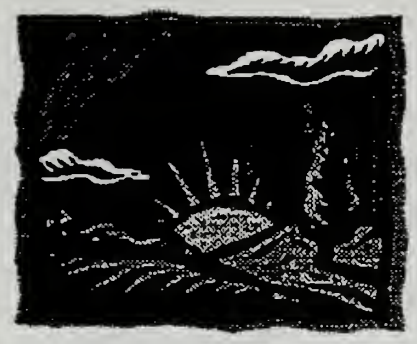
• We open the pages of our sacred texts and we read mostly about the lives of men. The prophet is a woman who breaks the silence of history by speaking women's names into the void. Rabbi Lynn Gottlieb

• Every time you don't follow your inner guidance you feel a loss of energy , loss of power, a sense of spiritual deadness. Shakti Gawain

• We tell you this:
We are doing the impossible.
We are teaching ourselves to be human. Martha Courtot

• Spirituality is basically our relationship with reality. Chandra Patel

• All creation teaches us some way of prayer. Thomas Merton



SPIRIT MAPPING

HOW WOULD YOU DESCRIBE YOUR CURRENT SPIRITUAL PRACTICE?

WHAT BENEFITS DO YOU REAP FROM A SPIRITUAL PRACTICE?

WHAT BARRIERS DO YOU COME UP AGAINST IN MAINTAINING A SPIRITUAL PRACTICE?

WHAT CHANGES OR ADDITIONS WOULD YOU LIKE TO SEE IN YOUR SPIRITUAL PRACTICE? AND WHAT CONCRETE STEPS CAN YOU TAKE TO MAKE THOSE CHANGES?

To allow ourselves to be carried away by a multitude

of conflicting concerns,

to surrender to too many demands,

to commit oneself to too many projects,

to want to help everyone in everything,

is to succumb to violence.

Thomas Merton

Barriers to Creating/Nurturing a Spiritual Path

____ Violence
____ Loss of Hope
____ Time
____ Feeling I am underserving
____ Negative-Bad experience with religion
____ Indulgent if I focus on spirituality
____ Self Centered
____ Too busy
____ Numb
____ Lack of knowledge of how to manage realities of criminal justice work and crime trauma, suffering, death
____ Overwork
____ Overactivity
____ High Stress
____ Inability to sit
____ Lack of personal caring - everyone else more important
____ Culture of POSSESSIONS
____ Poor Time Management
____ Unresolved grief
____ A hardened heart
____ Always taking short cuts to self care

Spiritual Expressions, Tools, Activities and Adventures

____ Chanting
____ Drumming
____ Art
____ Listening to Music
____ Singing
____ Meditation
____ Storytelling
____ Yoga
____ Sex - passion, igniting health and well-being
____ Stress Management
____ Massage - lowers blood pressure, boots your immune system, reduces stress
____ Tai Chi
____ Caring for animals - connecting
____ Attitude Adjustment
____ Healing from trauma, health
____ Healing from hurts, past
____ Exercise
____ Rituals
    ____ Birth
    ____ Celebrations - seasons, birthdays, weddings, funerals
    ____ Prayer
    ____ Mass
    ____ HAVING ONE DAY A WEEK OF REST
____ Sleep
____ Journaling
____ Goddess Worship
____ Herbal Rituals - tears, baths, lotions, foods, managing anxiety
____ Reading
____ Nutrition
____ Eating with awareness
____ Zen of eating
____ Centering
____ Mythology
____ Creating healthy relationships
____ Cleaning ones house
____ Reading the bible or other texts - Christianity, Judaism, Buddhism, Islam, Taoism
____ Being sensual

____ Exploring native spirituality
____ Humor
____ Studying religions of the world or their external truths
____ Holding, wearing, having symbols - reminders
____ Drawing
____ Painting
____ Traveling
____ Pilgrimage
____ Planting a Prayer
____ Letter Writing
____ Living Simply
____ Seeking enlightenment
____ Conversations on Hope
____ Writing your life and spiritual Journey
____ Conversing with God
____ Gesturing in Prayer
____ Nurturing our soul - Soulwork
____ Astronomy - study of heavens, planets
____ Bird watching
____ Gardening
____ Seeking harmony with people and creatures
____ Enhancing your interior and physical landscapes FENG SHUI
____ Aromatherapy
____ energizing, meditative, purifying, relaxing
____ Tarot Readings - Psychic Readings
____ Pendulum
____ Reiki - hand placements directing universal energy
____ Dream Journal
____ Workout
____ Swimming
____ Walking Meditation
____ Healing music - balancing our sound life
____ Painting - watercolor, finger-paints, oils, Chinese Brush Painting
____ Financial Responsibility & Management
____ Examination of Conscience
____ Compassion
____ Managing Physical Pain
____ Peacefulness
____ Gratitude

____ Accepting our humanity, our limitations
____ Writing Poetry
____ Witchcraft
____ Candles
____ Ancient Visiting - grandmothers, mothers, loved ones who have died
____ Friendship
____ Camping
____ Doing nothing
____ Sculpting
____ Handwork
____ Past-life exploration
____ X-Files
____ Learn from resiliency of victims
____ Contemplate
____ Forgive - if you can
____ Create a book of your favorite prayers or sayings
____ Pray with friends
____ Family prayers - grace, thanksgiving
____ Remember the sick
____ Watch your thoughts
____ Breathing exercises
____ Visualization
____ Day-dream
____ Live in the present moment
____ Be compassionate

Write for about twenty minutes a day. But write more if you want, or less. Try not to censor yourself. But if you're not ready to write about something, don't, yet; you will when you're ready.

Write what you need to write or want to write. Or write what you don't want to write.

Write what troubles you or what delights you. Can you link these feelings to events in your life? Write what you see, smell, taste, touch.

Write quickly if you choose, or write slowly and deliberately.

Write in long elegant sentences with lots of commas and semicolons (like William Faulkner). Or in short, choppy sentences (like Ernest Hemingway). However you write is fine.

Write without knowing what will be next. Write to surprise yourself. Or write and ponder and write and ponder some more.

Write outside or inside. Write leaning against a rock, a pad on your knees, or write at the kitchen table late at night after a long day's work.

Write in the morning or in the afternoon or in the middle of the night. Write when you're feeling rested or when you're exhausted after a long day's work.

Write when you're sick or when you're well. When all's serene or when it's chaotic.

Write lying on a sofa or propped up in bed or in the bathtub. Write in a library or on a subway or a bus or in a car sitting in traffic (like Isabel Allende did when writing her story "Two Words").

Save everything you write in a safe place. Read it, or don't. At first, it's probably best not to show your writing to anyone. Writing only for yourself will let you write more freely.

Chapter Two

How Writing Can Help Us Heal

The Health and Emotional Benefits of Writing

I became a writer out of desperation. . . .
When I was young, younger than I am now,
I started to write about my own life and I
came to see that this act saved my life.

JAMAICA KINCAID, *My Brother*

While my mother was dying, I walked into a bookstore to look for something to read as I sat next to her on my daily visits. Reading made the time pass. Reading made the time easier. I wanted to find something that would help me handle my complicated feelings.

During this difficult time, I had been writing in my journal to help ease the pain. I free-wrote whatever came to mind. Some days I described my writing (I was working on a novel). Or I wrote about daily events—meals made, friends seen, special moments or arguments with my sons, books read, my trip to the hospital. Other days I wrote about my feelings. Poured out my sorrow (about my mother's

illness), anger (that my mother was dying), grief (over my mother's loss and over my feeling that, because of her depression, I'd never really had a mother). Though I felt compelled to recount troubling events from my childhood, I deliberately avoided revisiting my past in any detailed way in the pages of my journal. To do so, I thought, would make me feel worse, would bring unbearable pain.

I didn't yet know that though I was journal-writing to try to help myself during this difficult time, my writing—just describing what I was doing or thinking or dumping my feelings onto the page—wasn't helping me. It was probably even making me feel worse. I wrote in my journal that I was depressed. I wrote, too, that "I don't want to write about it." Beyond this, I said little about my current feelings. (Writing "I am depressed" was as good as saying nothing about how I was feeling, about what I needed to say if I was to stop being depressed. Depression, I have recently come to believe, is a complex story that hasn't yet been told.)

I had been reading D. H. Lawrence's letters and several biographies about him. I learned how Lawrence wrote poems about his mother as he sat by her bedside while she was dying. He also began drafting an early version of *Sons and Lovers*, his novel exploring their complicated, loving, but painful, all-too-close relationship. This suggested that I, too, could begin writing about my mother, that I could draft some scenes from my childhood with her now, as I wanted to.

A line in one of Lawrence's letters captured my attention. "One sheds one's sicknesses in books—repeats and presents again one's emotions, to be master of them." Lawrence was saying that you could *use* your difficulties in your work and master your emotions if you represented them in your writing. "Representing," of course, means "describing." But it also means "re-presenting"—presenting scenes from the past as if they were presently occurring. This would undo, remedy, or rectify the effects of early experiences.

I was still, however, using my writing to fight the feelings I was having, to try to make them go away rather than representing them. I wasn't letting myself feel them deeply, explore them, understand them, learn their source, and link them to past and present events in my life. I was evading the narrative and emotional truth of my life. So my journal wasn't helping me understand and integrate my feelings during this complex time. I was stopping myself from writing my own life story. I feared I would find it unbearable.

As I searched the bookstore for works on grieving, on death and dying, I spotted James W. Pennebaker's *Opening Up: The Healing Power of Confiding in Others*. On impulse, I bought it. And I was grateful. For I found this book exactly when I needed it—both for my life and for my work.

As I sat next to my mother, I read Pennebaker. He described a special kind of writing I could use to deal with painful life experiences—with loss, death, abuse, depression, and trauma. I began to use it immediately in my journal writing, in the sketches I started penning of my early life. Later, I used what I learned, too, as I wrote my memoirs, *Vertigo* and *Breathless*, and all my subsequent work.

Learning to open up about everything in my past in the healing way Pennebaker described didn't happen all at once. Slowly, surely, though, I made important changes in how I wrote, in what I wrote, and, perhaps even more important, in how and what I felt as I wrote.

Opening Up summarizes ten years of scientific research into the connection between opening up about deeply troubling, emotionally difficult, or extremely traumatic events and positive changes in brain and immune function; it remains the best layperson's introduction to this research. (See the note at the end of this chapter for other sources.) Pennebaker's work on the relationship between suppressing our stories and illness, on the one hand, and telling our stories and increased health, on the other is well respected and pathbreaking in the field of psychology although not widely known by writers and would-be writers. In carefully controlled experiments, done while he was professor of psychology at Southern Methodist University in Dallas, Texas, Pennebaker

and his associates made the extremely important discovery that "writing can be an avenue to that interior place where . . . we can confront traumas and put them to rest—and heal both body and mind." Writing, then, seems to improve physical and mental health. But not just any kind of writing. Only a certain kind of writing will help us heal.

The Health and Emotional Benefits of Opening Up Through Writing

Pennebaker and his associate, Sandra Beall, tested the relationship between writing and wellness in the students they studied. All students were told to write in a journal for about fifteen minutes a day over a four-day period.

The first group was instructed to write about a trivial topic—a description of their living room, say.

The second group was instructed to write about their traumatic experiences. But they were subdivided into three groups to test three different ways of writing about trauma: (1) just venting emotions; (2) just writing what happened; (3) writing about events and emotions at the same time.

Those students writing about events *and* emotions about a trauma were told to "write continuously about the most upsetting or traumatic experience of your entire life," something that "has affected you very deeply." Ideally, it should be about something that the students hadn't talked about with others in any great detail. Students were told not to worry about "grammar, spelling, or sentence structure." But it was "critical" that "you let yourself go and touch those deepest emotions and thoughts that you have. In other words, write about what happened and how you felt about it then, and how you feel about it now."

Pennebaker and Beall learned that most students in this group reported they *had* experienced significant trauma in their lives; undisclosed trauma is not uncommon. When students' experiences in

writing about events *and* feelings were evaluated—by taking students' blood pressure, reading their journal entries, studying follow-up questionnaires about their entries and their emotions—Pennebaker and Beall discovered that the impact of writing about trauma was "far more powerful" than they had predicted.

Students wrote quickly and at length. Many students "cried as they wrote." Many reported "dreaming about their writing" over the four days of the study. Many revealed "intimate feelings" they hadn't before shared.

Many depicted "profound human tragedies"—some that hadn't before been revealed. One student remembered the "hot summer night" his father took him into their backyard to tell his nine-year-old son that he was divorcing the boy's mother because "things haven't been the same since you and your sister were born." Another wrote of how, at ten, she hadn't picked up her toys when told to do so by her mother and how her grandmother had fallen, broken a hip, and died a week later during surgery. A third wrote of her complex feelings of being sexually abused by her grandfather when she was a teenager and of the "terrible conflict" she faced, for she felt physical pleasure and intense love for him, yet betrayal and violation. Other students wrote of the death of a family member or friend, interpersonal and family conflicts and family abuse, being gay, alcoholism, suicide attempts, illness or injury, anger at parents' divorces, public humiliations. Many reported feeling saddened, troubled, and dismayed by their writing.

Pennebaker and Beall were initially discouraged that the writing had stirred such negative feelings in these students, especially because students in the other groups (those who wrote about trivial subjects or who wrote only about emotions or events) initially felt more positive about their writing. They were concerned that the students linking events and feelings about trauma didn't immediately feel better, as they had anticipated. (Students, though, were reporting *appropriately* difficult feelings about the traumas they were describing; there is nothing wrong with having difficult feelings about something bad you've experienced.)

Four months later, though, the students writing about events and feelings reported that their spirits had improved significantly—that

their writing had helped them resolve a difficult issue. "Writing about their deepest thoughts . . . resulted in a more positive outlook."

The important discovery Pennebaker and Beall had made, then, was that *to significantly improve your spirits long-term, you must endure difficult feelings initially.*

Six months after the experiment, Pennebaker and Beall studied the health of these students by counting visits made to the student health service before and after the writing days.

Before writing, all students visited the health center at the same rate. After writing, visits by students who wrote about superficial topics or *only* about their emotions or *only* about traumatic events (without describing feelings) were roughly the same. But after writing, visits by students who wrote about both what happened and how they felt about it dropped by 50 percent.

Pennebaker and Beall reached their landmark conclusion (later replicated by other investigators and confirmed in more sophisticated follow-up studies) that simply writing about trivial topics or only venting one's feelings about trauma or only describing traumas isn't sufficient to improve health. *To improve health, we must write detailed accounts, linking feelings with events.* The more writing succeeds as narrative—by being detailed, organized, compelling, vivid, lucid—the more health and emotional benefits are derived from writing.

Through writing, these students had achieved a cathartic discharge of complex, pent-up feelings. But, too, they had reflected upon the significance of these events, attaining insight into their traumas and achieving some distance from them. Through writing about events *and* feelings, students integrated the two; they understood what had occurred and what they felt about it, and they assimilated the meaning of this event into their lives, thereby diffusing its power over them.

One student wrote, "Although I have not talked with anyone about what I wrote, I was finally able to deal with it and work through the pain instead of trying to block it out. Now it doesn't hurt to think about it." Another: "I had to think and resolve past experiences. . . . One result of the experiment is peace of mind, and a method to relieve

emotional experiences. To have to write emotions and feelings helped me understand how I felt and why."

Another, later study ("Confession, Inhibition, and Disease") examined brain wave activity in people confronting traumas. Pennebaker discovered that for students who explored feelings about traumatic events as they wrote, there was a congruence in brain wave activity between the left and right hemispheres, indicating that both emotional and linguistic information was being processed and integrated simultaneously. This, then, in terms of brain function, is what achieving "integration" means.

Other experiments established that people who linked traumatic events and feelings in this way had "T Lymphocytes [that] were more 'energetic' than the control group." Their bodies, then, were more able to fight infection (having greater antibody response to Epstein-Barr virus and hepatitis-B vaccination, for which they were tested) than before writing. Their heart rates lowered. Other tests showed, too, that they were in a more relaxed physiological state.

The act of linking feelings with troubling events, then, makes our bodies display responses associated with yoga and meditation. This explains why writers who stop work soon feel out of sorts—why they become edgy, irritable, anxious, even depressed. This explains, too, why people who begin writing report feeling a greater sense of well-being—why they become calmer, more capable of coping with stress, more serene, even when facing life's challenges, than they'd been before.

Writing thoughtfully and emotionally about traumatic experiences, rather than writing about superficial topics or venting feelings or simply describing what happens, seems to improve our immune system. And this improvement, in Pennebaker's subjects, tended to last for six weeks.

Further experiments with other groups of students and people in distress (people laid off from jobs; people whose spouses had died tragically; people with illnesses) showed that substantial behavioral changes

are also associated with this kind of writing. Students' grades improve. People get new jobs more quickly. People are absent from work less. Grieving people are healthier. Sick people are somewhat healthier; if they are terminally ill, they seem, nonetheless, to be in a state of emotional and spiritual healing—more accepting, secure, serene.

Pennebaker and his associates had tested the theory that *repressing* thoughts and feelings about traumatic or distressing events might be linked to illness and that *expressing* thoughts and feelings through writing about traumatic or distressing events might prompt significant improvements in health.

Over time, Pennebaker explains, the work of inhibiting traumatic narratives and feelings acts as an ongoing stressor and gradually undermines the body's defenses. Like other significant stressors, inhibiting our stories and our emotions can adversely affect immune function—"the action of the heart and vascular systems, and even the biochemical workings of the brain and nervous systems."

Many researchers have observed that survivors of childhood sexual abuse and other traumas (like rape) or the suicide or accidental deaths of people close to them, if they do not discuss these events, tend to develop more major illnesses than people who do express their feelings. Often, though, the trauma remains undisclosed because, though people would like to discuss it, they can't or won't because they fear punishment, embarrassment, or disapproval or because they can't find an appropriate audience. So, many people actively stop themselves from telling their stories; they inhibit their need to tell their traumatic narratives. This, though, "deplete[s] immune functioning, and increase[s] incidence of physical illness."

Confronting the chaos of our most difficult memories and feelings, though, and translating them into coherent language can have "remarkable short- and long-term health benefits." For when we deal with unassimilated events, when we tell our stories and describe our feelings and integrate them into our sense of self, we no longer must actively work at inhibition. This alleviates the stress of holding back

our stories and repressing or hiding our emotions, and so our health improves.

What Kind of Writing Helps Us Heal?

Writing that describes traumatic or distressing events in detail *and* how we felt about these events then and feel about them now is the only kind of writing about trauma that clinically has been associated with improved health. Simply writing about innocuous subjects (like what we did throughout our day) or simply writing about traumatic events or venting our feelings about trauma without *linking* the two does not result in significant health or emotional benefits. In fact, in one experiment, it was found that simply venting feelings might have made the writers somewhat sicker.

In other words, we can't improve our health by free-writing (as I had been using my journal) or by writing objective descriptions of our traumas or by venting our emotions. We cannot simply use writing as catharsis. Nor can we use it only as a record of what we've experienced. *We must write in a way that links detailed descriptions of what happened with feelings—then and now—about what happened.*

Both thinking and feeling are involved. Linking them is critical. Feelings about the traumatic event in the past and the present are expressed and, perhaps, compared so that the writer unravels how the past impinges on the present but how, too, it's different.

In controlled clinical experiments, then, only writing that describes *traumatic events and our deepest thoughts and feelings about them, past and present, is linked with improved immune function, improved emotional and physical health, and behavioral changes indicating that we feel able to act on our own behalf.* And this was accomplished in the experiments by only one hour of writing—fifteen minutes a day—over a four-day period!

Later studies showed that the more days people wrote, the more beneficial were the effects from writing. And these benefits occurred despite educational level: people with sixth-grade educations benefited

as much as those with advanced degrees. "Sickly" people benefited more perhaps than "well" people. Women benefited more perhaps than men. And the positive effects of writing did not depend upon getting any feedback on the writing or even upon anyone reading what was written.

If the positive effects of writing over four days lasted for six weeks, and the benefits of writing for longer periods lasted longer, then it seems evident (though Pennebaker never makes this connection) that engaging in an ongoing writing program—even a simple one—can provide ongoing health and emotional benefits.

Guidelines for Confronting Trauma in Writing

Soon after reading Pennebaker, I wrote some guidelines, derived from *Opening Up,* that I copied onto an index card and used as a place marker in my diary. I still use them to remind me how to write in a healing way.

Do's

1. Write twenty minutes a day over a period of four days. Do this periodically. This way you won't feel overwhelmed.
2. Write in a private, safe, comfortable environment.
3. Write about issues you're currently living with, something you're thinking or dreaming about constantly, a trauma you've never disclosed or discussed or resolved.
4. Write about joys and pleasures, too.
5. Write about what happened. Write, too, about feelings about what happened. What do you feel? Why do you feel this way? Link events with feelings.
6. Try to write an extremely detailed, organized, coherent, vivid, emotionally compelling narrative. Don't worry about correctness, about grammar or punctuation.

7. Beneficial effects will occur even if no one reads your writing. If you choose to keep your writing and not discard it, you must safeguard it.
8. Expect, initially, that in writing in this way you will have complex and appropriately difficult feelings. Make sure you get support if you need it.

On the other side of my notecard, I wrote a set of warnings I'd gleaned from Pennebaker:

Don'ts

1. Don't use writing as a substitute for taking action.
2. Don't become overly intellectual.
3. Don't use writing as a way of complaining. Use it, instead, to discover how and why you feel as you do. Simply complaining or venting will probably make you feel worse.
4. Don't use your writing to become overly self-absorbed. Overanalyzing everything is counterproductive.
5. Don't use writing as a substitute for therapy or medical care.

Beginning to Write in a Healing Way

Since reading Pennebaker, I have applied what I learned about confronting my early traumas and my present difficulties. I had feared that writing about what had happened to me as a child, and my feelings about it, would make me feel worse. I had feared that examining present problems would intensify my negative feeling. I learned, though, that writing about traumatic or difficult or complex events *and* feelings as described here helped me immeasurably. In my lifelong project of using my writing to unravel the meaning and the feelings about my past, I have revisited my past one moment at a time. Doing so has recast the meaning and significance of my life, has helped me heal.

WHAT YOU CAN DO NOW Try enacting the writing plan outlined here. Remember to link events with feelings; to write in a detailed way; to tell a complex story; to describe feelings in the past and in the present.

Do this on four or more successive days. Remember that, like Pennebaker's subjects, you might have some difficult feelings. Make sure you have someone with whom to discuss them, if necessary. You can write, too, about the feelings raised by your writing.

Initially, it's probably best not to share your work or to reread it.

Note: James W. Pennebaker's *Opening Up* was originally published in 1990 by William Morrow and was intended for the general reader. His prior works included *The Psychology of Physical Symptoms* and *Mass Psychogenic Illness.* The specialized books and scores of articles that Pennebaker used to write *Opening Up* (many of which I've subsequently read, some of which are in my Sources and Further Reading) are listed in his "Notes" to the volume. *Opening Up* remains the best general and most readable introduction to this research. Pennebaker's study linking left- and right-brain wave activity is "Confession, Inhibition, and Disease."

After the publication of *Opening Up,* many major periodicals reported on the significance of Pennebaker's findings. Articles appeared in *American Health, Omni, Psychology Today, The New York Times, Prevention.* A subsequent excellent rethinking of the issues in *Opening Up* can be found in Kent D. Harber and James W. Pennebaker, "Overcoming Traumatic Memories," in *The Handbook of Emotion and Memory: Research and Theory,* ed. S. E. Christianson (Hillsdale, NJ: Lawrence Erlbaum, 1992).

Dr. Edward J. Murray, professor of psychology at the University of Miami, in a March 7, 1991, *New York Times* article said that though he initially questioned Pennebaker's findings, his own follow-up work showed that "writing seems to produce as much therapeutic benefit as sessions with a psychotherapist."

Chapter Three

Writing as a Therapeutic Process

How Writers See It

Two or three things I know, two or three things I know for sure, and one of them is that to go on living I have to tell stories, that stories are the one sure way I know to touch the heart and change the world.

DOROTHY ALLISON,
Two or Three Things I Know for Sure

Give sorrow words. . . .

WILLIAM SHAKESPEARE

When I was in high school (a million years ago, as my son Justin always informs me), we used a literature textbook remarkable not so much for what it contained, but for what it didn't. In its five hundred pages, there was no photo, no realistic portrait, to suggest that the works we read had been written by living, breathing, feeling, thinking writers. There was nothing to indicate that "real" writers often wrote to heal their emotional wounds and that I, too, could write to help myself in this way.

The most human representation of the writer that we saw was the familiar etching of William Shakespeare that had originally graced the title page of the first folio. I remember myself at fifteen, staring at it, trying to penetrate the mystery of how that frozen being could have penned works of majestic power, of longing and yearning. I wanted to know what his life had been like and what had happened to him that needed to be expressed, so I embarked on a long, self-initiated research project to learn whatever I could about his life. It wasn't much.

Still, audacious as it seems, I identified with Shakespeare, and with other writers, too. I wanted to scribble impassioned sonnets about how you could never truly possess someone you loved, about the effects of the passage of time, about how our desires are often thwarted by circumstances beyond our control. I wanted to record in my black-and-white speckled notebook my reflections about love lost and love found. I wanted to write about how much I hated my father, how much I resented taking care of my sister, how my grandmother and mother were always fighting, how my mother was often depressed. I wanted to write memories of Hoboken, the place we'd moved from, the only place I'd felt at home. I wanted to write how I thought the suburb of Ridgefield, New Jersey, was the most boring place on earth.

But I never got past filling the first several pages. For what I wrote seemed awful, nothing like the perfect essays and stories we were reading in school. True, I'd won an award for my writing in grammar school for an essay called "Safety in the Home, Street, and School." But that writing was different. It wasn't about my personal life. It wasn't about "the real me," as I liked to call the person I believed was my essential self.

The truth was that I didn't believe a person as ordinary as I was could ever write anything of significance—even anything that could be personally useful, that might enrich my being. But I had a *need* to write. It grew from my pain in living in a difficult household, my sense of difference, my internal, perpetual gloom from the events of my childhood, which couldn't be driven away no matter how hard I tried.

Had I known that famous writers often started their work out of the same sense of desperation, grief, loss, and longing that I felt, I might have permitted myself to begin writing. And to continue writing. And my days might have been more vivid, less cloudy.

Secretly, though, I hoped that someday, by some miracle, I might become a writer. I prayed to become a writer in the same way that I prayed to have big breasts. I hoped that I'd wake up on my sixteenth birthday with both wishes fulfilled.

I had no model, though, for what the act of writing was like. In school we were given writing assignments to do at home, which the teacher marked (one grade for content; another for grammar and style). But there was no talk of the "writing process"; no instruction in the creative stages of bringing a long work to fruition; no discussion about how writers used their work to explore traumatic events. As with so much else, we were on our own.

I didn't know that if you want to write, you must follow your desire to write. And that your writing will help you unravel the knots in your heart. I didn't know that you could write simply to take care of yourself, even if you have no desire to publish your work. I didn't know that if you want to become a writer, eventually you'll learn through writing—and only through writing—all you need to know about your craft. And that while you're learning, you're engaging in soul-satisfying, deeply nurturing labor. I didn't know that if you want to write and don't, because you don't feel worthy enough or able enough, not writing will eventually begin to erase who you are.

I didn't know that the writers whose works we read harbored hopes and dreams like mine when they were young but that they acted on their desires, whereas I wasn't acting on mine. I didn't know that they kept writing notebooks as children and as adolescents; that their youthful attempts at keeping journals, at constructing essays, poems, and stories, were as flowery or pompous or inept or as full of promise as my few aborted attempts. And so my need to use writing as a process of self-discovery, self-enrichment, and self-healing was derailed for twenty years.

Telling the Story That Must Be Told

The writer Nancy Mairs, who grew up when I did, had the same experience, the same feelings. In a diary she kept in 1958, she wrote, "I want so desperately to express myself. I can't stand this suppression. I want to write, to act, to sing, anything. I can't. I can't." In 1959 she wrote, "I am so empty, so hungering. I know that deep within me lies something but I see it in comparison with the talents of others & it is so pitifully small."

Mairs believes repressing her desire to write exacerbated the suicidal depression that she survived as a grown woman and that, eventually, writing helped her understand. I, too, now believe that the way out of depression lies in finding the story that hasn't been told, that must be told, and in exploring the feelings that narrative engenders—in writing it down.

Like so many young people, neither Mairs nor I was encouraged to follow our desires to write. There are few parents like the New Zealand writer Janet Frame's mother, who ask their children for poems, or like Virginia Woolf's mother, who encourage their children to publish a family newspaper. Often, when I wrote as a child, I was interrupted, told to "get busy," do my homework, help with the dishes, play Monopoly with my sister. I didn't know that for all writers there is an apprenticeship period and that the sooner we begin, the better. Virginia Woolf started taking herself seriously as a writer when she was fifteen, though other writers, like Harriet Doerr, author of the novel *Stones for Ibarra,* or like the poet Amy Clampitt, didn't begin writing or publishing until they were elders.

If we commit ourselves to engaging in the process of writing, our work will evolve and mature. Becoming competent takes time, and we all have within ourselves the capacity to do it. Yet instead of being helped to achieve this healing insight, I was taught that, in the words of one of my English teachers, when it comes to being a writer, "you either have it or you don't."

This simply isn't so.

Works of literature were created, I was told, because the writers wanted to make objects of beauty, not because they needed to understand life's difficult, perplexing, or traumatic moments. Art for art's sake, I thought, not art for the sake of life. As a young woman, I didn't have the opportunity to learn what I needed to know: that famous writers had written the stories they needed to tell in order to help themselves heal from the traumatic events in their lives. And that I, too, could help myself immeasurably by writing about my pain.

Honoring the Desire to Write

What aspiring writers need to begin and continue writing is unconditional acceptance of their *desire* to write. And they need to honor that desire. Aspiring writers must understand that if you want to write for an audience, learning to write, just like learning anything else, takes time and that we must be realistic and patient with ourselves while we're learning. Meantime, the very act of writing will dispense its curative benefits. Neither Nancy Mairs nor I was taught this when we were young, hopeful writers.

A Few Words About Thwarted Desire

Desire. If we have always wanted to write—something, anything—and if we haven't, our desire won't disappear. Our need won't dissipate. Our stories won't go away. Our traumas won't heal themselves.

Each time we think about our unenacted desire, we will feel thwarted, diminished, unfinished, incomplete. Repressing our stories can harm us, as Nancy Mairs's experience proves.

As a girl, my mother wanted to become a writer, but she never realized her desire. I don't know much about her early life. But I think what she needed to explore was the profound impact of her mother's death from influenza, the near-lethal abuse and neglect of her caregivers, the damaging effect of a life lived in extreme poverty with a father whose railway work took him away for long periods, and the

hatred of her stepmother. Not writing about this negatively affected her, I'm sure, for she had no outlet for her complex emotions.

Though she wanted to write, it was the thirties, and money was scarce, and her income from selling shoes was needed by her family. She couldn't use the scholarship she was awarded to go to college.

Throughout my youth, my mother let me examine the medal, engraved with her name, that she had been awarded for her writing in high school. She wore it on the lapel of her Sunday suit throughout her life. Seeing it made me sad. It became the image of what my mother wanted but didn't pursue. Though she was the best writer in her class, the only writing she managed in adulthood were exquisitely phrased, weekly letters to my children while they were in college. She wrote about how everyone in the family was doing; she even wrote about our animals. She never wrote about herself.

"I've *always* wanted to write a novel; I'll get around to doing it one of these days," a man I know often told me. Once, exasperated—for by now he was in his fifties, with a heart condition, and he had been complaining for fifteen years about how unfulfilled he felt—I told him, "Look, you must think you're immortal. You're acting like you're going to live forever. You're not getting any younger. If you want to write, you better start today or your time might run out."

And he did. Writing reinvigorated his life, for he began to liberate the stories he'd held captive within him—about his longing for fatherly love, about his orphanhood and his lifelong sense of isolation, loneliness, and unworthiness. He started traveling to the remote Australian locations he wanted to use in his work, studying the habitats of wildlife, trekking in the wilderness, making new friends, sharing his newfound passions with his wife.

Writing as Symbolic Repair

In *Creativity as Repair*, Andrew Brink has observed that the impulse to create usually comes from some early damage to the self. Doubt, pain,

trauma, insecurity, uncertainty—these feelings are the fuel that drive the creative process. This wound or loss initiates a life's work of healing, "of trying to make right what early went wrong." Writing, then, uses language to repair psychic wounds.

David Aberbach, in *Surviving Trauma: Loss, Literature, and Psychoanalysis*, says something similar. Creativity, he has discovered, more often than not is spurred by painful loss and unresolved or thwarted grief. In his study of the writing done by survivors of the Holocaust and of post-traumatic stress disorder, Aberbach has found that writing is a significant way "to . . . master trauma in all its horror and overcome it" and "to complete the work of mourning." Trauma and loss are both the subject of the writing and the motive behind doing the work.

Recently, I've read many literary works that, according to their writers, were written expressly so that their authors could heal from a psychic wound. In her memoir, *Two or Three Things I Know For Sure*, Dorothy Allison describes how her writing *Bastard Out of Carolina* evolved from her need to tell the story of how she was raped by her stepfather when she was five years old. "When I began," she wrote, "there was only the suspicion that making up the story as you went along was the way to survive." Junot Díaz, author of *Drown*, a montage of stories set in Santo Domingo's Barrio XXI and in London Terrace near Perth Amboy, New Jersey, has said in an interview that he wrote to overcome the losses he incurred by living through colonialism, emigration, and poverty and his grief at his brother Rafa's illness. Díaz began by "scribbling long letters to Rafa" when he was hospitalized. In his memoir, *Imagining Robert: My Brother, Madness, and Survival*, Jay Neugeboren relates how writing helped him manage his feelings about his brother's mental illness by helping him bring order to his chaotic experience; he eulogized, too, the brother that illness had robbed from him. In *My Dark Places: An L. A. Crime Memoir*, James Ellroy says he became a writer because his mother was murdered, an event that left him obsessed with crime and crime novels; by writing, he tried to discover what happened to her and to deal with his often self-destructive grief and rage. In Renée Roth-Hano's autobiographical novel *Touch Wood: A Girlhood in Occupied France*, the author describes

how the magnitude of her losses propelled her to write about her pain as a survivor of the extermination campaign of the Nazis; about her life as a hidden child in a convent in Normandy during the Nazi occupation of France; about her separation from her parents, terror of discovery, and grief almost beyond words at losing the eighty-nine people she knew who were killed by the Nazis and also at the loss of her father, who died shortly after the war.

Writing from Grief

In Isabel Allende's *Paula* (a memoir about her daughter's terminal illness and death), Allende describes how she began writing *House of the Spirits*, the novel that catapulted her to fame. Not meant to be a work of fiction, intended for publication, the book was written more personally, because of her profound grief.

She started it as a letter to her grandfather when he was nearly one hundred. He was dying in Chile in the Santiago mansion where the novel is set. Allende was raised there but couldn't return to keep her promise to attend him, for she was in exile in Venezuela after the murder of her uncle, the former Chilean president Salvador Allende.

Until she began this "letter" to her grandfather, Allende didn't believe she could be a writer. For she had been trained to think women weren't supposed to be creative. But after learning of his impending death, she needed "to say good-bye" in writing.

He had been a "conservative, a patriarch, a very violent person," but she "loved him dearly." Allende wanted to assure him that his history wouldn't be obliterated. She would record the stories he'd told her. The first, which begins *House of the Spirits*, was "an anecdote about my great-aunt Rosa, my grandfather's first sweetheart, a young girl of almost supernatural beauty who had died in mysterious circumstances shortly before they were to marry."

As the stories poured out, Allende wrote as if in a trance. She felt she was "unwinding a ball of yarn."

That personal letter to her grandfather grew to a five-hundred-page manuscript that Allende carted in a canvas bag everywhere she went. Still, though, she couldn't admit she had begun a novel. That idea "seemed presumptuous."

Writing *House of the Spirits*, says Allende, "saved my life." She began her career for the purely private motive of expressing her grief, as a form of self-care. Through writing, she said, "the world became more tolerable. Living with myself was more tolerable too."

Writing to Give Form to Devastation

After Allende's daughter, Paula, lapsed into a coma, apparently because her treatment in a Spanish hospital during an attack of porphyria had been bungled, Allende rarely left her daughter's bedside. Carmen Balcells, her literary agent, sensing Allende's desperation and pain, arrived at the hospital one day, bearing gifts. Dozens of red roses. Nougats from Alicante. An "obscene-looking sausage." And, most important, "a ream of lined yellow paper," which Carmen deposited into Allende's lap.

"My poor Isabel," Balcells said. "Here, take this and write. Unburden your heart; if you don't you are going to die of anguish."

"I can't," Allende protested. She told Balcells that something inside her had "broken," that she felt she'd never write again.

But Balcells commanded Allende to "write a letter to Paula. It will help her know what happened while she was asleep." She told her to write instead of suffering wordlessly, insisting that her friend avail herself of the help that writing had offered her in the past. Balcells knew that without the release of words, Allende's health would be seriously compromised, that she was herself, literally, in mortal danger, for the chance of getting a serious illness in the wake of a family member's serious illness is very high.

And so Allende began writing a letter to her comatose daughter, Paula, to tell her about the life she was missing: "this is how I entertain myself in the empty moments of this nightmare."

"My soul is choking in sand. Sadness is a sterile desert," Allende wrote. "I plunge into these pages in an irrational attempt to overcome my terror. I think that perhaps if I give form to this devastation I shall be able to help you, and myself, and that the meticulous exercise of writing can be our salvation."

The personal letter Allende wrote to Paula soon grew into a more ambitious undertaking: to explain herself and her past and their family history of political oppression and exile to her daughter when she awakened. And to explain it, too, to herself. For although Allende had written of her past fictionally, she hadn't yet taken time to discover her feelings about past events in a way that would allow her to understand and integrate the terrible, ongoing losses she had sustained—of a country, of friends and family through political persecution, of landscape, of language, of cherished personal possessions.

Her daughter's illness impelled her to understand her life differently. "You, Paula," Allende writes, "have given me this silence in which to examine my path through the world, to return to the true and the fantastic pasts, to recover memories others have forgotten, to remember what never happened and what still may happen. Mute, paralyzed, you are my guide. . . . I spend my hours by your side, writing."

Allende describes her work as "therapy." Other people "go to a therapist . . . to talk about the world and about life and the pain of living. I do it through my writing." (Since Paula's death, though, Allende has begun therapy to help her with her loss.)

Before, Allende believed her past had "little meaning"; "I can see no order to it, no clarity, purpose or path, only a blind journey." After, though, Allende realized her life had been one of perpetual loss that began with the disappearance of her father after a sexual scandal—he was caught wearing women's clothes making love to a man—when she was three. She examines the end of her innocence—how, at age eight, being molested by a fisherman whom the next morning she found dead from a blow on the head had "left a scar" she never before understood.

But throughout her life, painful events had always been muted by the act of storytelling—first, her mother's compensatory stories of "an imaginary world where we were all happy," then, later, her own.

Though Allende could not save her daughter—she died a year later in Allende's arms—giving form to her pain allowed Allende to feel her despair, allowed her to connect it to the events in her life that occasioned it, even as it kept her despondency manageable.

"I had a choice," Allende says. "Was I going to commit suicide? . . . Or was I going to write a book that would heal me. . . . I went on writing because I could not stop. I could not let anger destroy me." So, through writing, Allende chose to live; through the act of writing, she began to integrate this and other traumatic experiences into her life. She believed, too, that there was a lesson in Paula's dying that she learned as she wrote: the virtues of "patience, courage, resignation, dignity in the face of death."

"To lose Chile and all of my past because of the military coup and being forced into exile pushed me to write *The House of the Spirits.*" Losing her political innocence, becoming aware of "the disappeared, the tortured, the dead, the brutal repression throughout Latin America, impelled me to write *Of Love and Shadows.*" And losing her daughter impelled Allende to write *Paula.* Writing, though, for Allende, "is a way of recovering what is lost." Though all Allende's writing comes from painful, deep, long-standing emotion, she says "the process of writing even if the theme is heavy is *wonderful.*"

Allende's work shows how creative writers use writing as a way of healing, of transforming despair into understanding and (in time) acceptance. It shows how writing that springs from intensely personal motives can be useful to others. For loss is a universal human experience, something we all must learn to deal with. Sharing our stories of loss, and accepting loss as a common feature of life, Allende says, helps us "enjoy the good moments all the more." As the novelist Amy Tan observed, Allende isn't "simply a story teller, she's a story giver."

Freedom. Autonomy. Power. Wisdom. Soulfulness. These words recur when writers speak of the effect of doing their work, of writing about

the traumatic moments in their lives. As a writer like Isabel Allende shows us, we, too, can write to heal ourselves if our writing comes from a deep, authentic need. If we write about our pain, we heal gradually instead of feeling powerless and confused, and we move to a position of wisdom and power.

Writing as Self-Analysis

In Virginia Woolf's memoir, "A Sketch of the Past," there is an unequivocal statement about how her need to write came from the pain she'd experienced in childhood. By writing her autobiographical novel, *To the Lighthouse*, Woolf says, she "rubbed out" the impact of her father's violence by writing about it, and she quelled her mother's voice—the one telling her that the only proper role for women was to serve men—which formerly had obsessed her. Woolf believed that by writing "I did for myself what psychoanalysts do for their patients. I expressed some very long and deeply felt emotion. And in expressing it I explained it and then laid it to rest." The process wasn't simple or easy. It involved reexperiencing her past in a new way. But she *deliberately* used her writing as self-analysis to examine and integrate deeply felt yet unexpressed emotions linked to the troubling events of her past.

A Caveat

Many writers, like Woolf, describe their work as a form of analysis or therapy. And in the days before treatment was generally available, we know that many other writers used their work in this way. Many writers now also do their work without therapy or analysis; some fear that entering therapy might rob them of their creative drive. But although I, too, have found my work to be immensely beneficial and therapeutic, I personally believe it is essential for people wanting to write about extreme situations to have skilled professional support while writing or to attend a reputable support group.

In my writing groups, and with peers, I always strongly urge that

while we're confronting trauma through our writing, we do it with the help of support and guidance. Some people I know have chosen to attend support groups like bereavement groups, Alcoholics Anonymous, incest survivor groups, or cancer survivor groups rather than enter therapy.

Some forms of therapy even employ writing. I have discovered in my own work that these processes are mutually beneficial; my work deepens because of my therapy; but my therapy progresses because of my work.

As David Aberbach has warned, writing, though it may be therapeutic, isn't therapy. But keep in mind as well that therapy isn't writing.

Why, then, should we write? Because writing permits the construction of a cohesive, elaborate, thoughtful personal narrative in the way that simply speaking about our experiences doesn't. Through writing, suffering can be transmuted into art. And writing permits us to use our writing as a form of public testimony in a way that the private act of therapy doesn't.

Finding Order Through Writing About Trauma

In her memoir, "A Sketch of the Past," Woolf used writing to heal. She started "without stopping to choose my way, in the sure and certain knowledge that it will find itself."

She began with some early memories: of sitting on her mother's lap; of "lying half asleep, half awake, in bed" in the nursery at Talland House, St. Ives, the family's country house in Cornwall.

But she soon found herself exploring some difficult feelings—what she called her "looking-glass shame," how looking in a mirror and seeing her reflection made her feel worthless. This feeling she traced to the looking glass in the hall at St. Ives and how, as a child, she was ashamed or afraid of her body, of seeing it in the mirror.

Through writing, she linked her feeling of shame with the memory of an important event that she was probably recalling for the first time —of how, at six or seven, she was sexually assaulted by her half-brother

Gerald Duckworth on the ledge in the same hall where the mirror hung and how she probably watched herself being violated in the mirror.

She describes how Gerald lifted her onto the ledge, and "as I sat there he began to explore my body. I can remember the feel of his hand going under my clothes; going firmly and steadily lower and lower. I remember how I hoped that he would stop; how I stiffened and wriggled as his hand approached my private parts. But it did not stop. His hand explored my private parts too." Recapturing what she felt then, she says she remembers "resenting, disliking" it. She felt, too, that "it is wrong to allow" parts of the body "to be touched," indicating she felt responsible for what happened and, perhaps, as a grown woman, still did.

In writing "A Sketch of the Past," Woolf wanted to recreate, in detail, the events of her childhood and to explore her feelings about these events. She had given herself precisely the task James W. Pennebaker gave his student subjects. She gave herself permission to remember, to feel, to articulate her recollections.

She wanted to explore what she felt now and what she *remembered* feeling. She wanted to link these feelings to events by taking herself back in time to specific "moments of being." Through describing them, she would discover the key to her development.

She wanted to discover the source of her difficult adult feelings and character traits: her hopelessness, despair, shame, depression, but also her creativity, resilience, strength, intellectual curiosity, integrity, and courage. What she discovered was that *through writing* she transformed the effects of harmful events into something meaningful.

Writing was Woolf's way of constructing reality, of redefining herself. She found the underlying patterns of life that hide behind appearances. This changed her view of the world from one of a chaotic place to one that was orderly though in need of change. "It is only by putting it into words that I make it whole," Woolf said. "This wholeness means that it has lost its power to hurt me; it gives me, perhaps because by doing so I take away the pain, a great delight to put the sev-

ered parts together. From this I reach what I might call a philosophy; . . . that we—I mean all human beings—are connected with this; that the whole world is a work of art; that we are parts of the work of art."

The Therapeutic Process of Examining Our Pain

The therapeutic process of writing goes something like this:

We receive a shock or a blow or experience a trauma in our lives. In exploring it, examining it, and putting it into words, we stop seeing it as a random, unexplained event. We begin to understand the order behind appearances.

Expressing it in language robs the event of its power to hurt us; it also assuages our pain. And by expressing ourselves in language, by examining these shocks, we paradoxically experience delight—pleasure, even—which comes from the discoveries we make as we write, from the order we create from seeming randomness or chaos.

Ultimately, then, writing about difficulties enables us to discover the wholeness of things, the connectedness of human experience. We understand that our greatest shocks do not separate us from humankind. Instead, through expressing ourselves, we establish our connection with others and with the world.

Writing and Psychic Growth

Henry Miller is as different a writer from Virginia Woolf as one can imagine. Yet in reading his work I learned that he conceived of his writing in similar terms.

The shock Miller responded to in his writing, which occurred in his adult life, was his wife June Miller's leaving him for a woman, their mutual friend, Jean Kronski. After June and Jean fled to Paris, Miller became seriously suicidal, for he believed he could never sustain the loss of June. He even wrote June a suicide letter.

But then one night, after he was finished with his work for the day at the Office of the Parks Commission, in Queens, New York, in a mood of "utter despair," he sat in front of a typewriter and, without knowing what he was doing, began to outline a work about their lives together and how June had betrayed him.

He would begin the work with the first time he saw her at a taxi-dancing hall in Times Square and he was immediately captivated by her beauty and sensuousness and he knew he would have to leave his wife for her. He would describe leaving his first wife, Beatrice, and their divorce and his guilt feelings about leaving his young daughter; his and June's abortive attempts to earn money; June's "gold digging" and whoring for him; Henry's early amateurish attempts at fiction; Jean's entrance into their lives; their drugged-out ménage à trois; and how Jean and June ran out on him.

Miller worked through the night. By morning a stack of thirty-two closely typed pages sat on his desk. *June,* he labeled it. It was the outline for *Tropic of Cancer, Tropic of Capricorn, Sexus, Nexus,* and *Plexus,* the books that he would write over the next thirty years!

He realized, when finished, that he was exhausted, but, "no longer wracked by emotion, he was strangely calm." He decided that after resting he would cable June to disregard his suicide note: instead of killing himself, he would write his way out of pain; in only outlining his book, he had "achieved some peace."

All Miller's novels were prompted by the shock of his losing June. But he believed his work matured because of his loss. Without this trauma, he said he would have had nothing substantial to express. For what he embarked upon was a period of intense soul searching. Before his loss, he lived his life unconsciously. After, in writing *Tropic of Cancer,* he discovered who he was, and he created a personal mythology about his role in life as an anarchic, iconoclastic, virile, tough, tender-hearted, working-class intellectual—a personal myth that could sustain him. Before writing about June, he thought himself a failure; after, he believed that his struggle and success in expressing himself, in breaking the silence of men like himself who hadn't been educated past high school, was heroic and that June's sacrifices had, in fact, enabled his work.

Through the years, Miller developed a profound and important philosophy about the creative process that he expounded in his novels, in letters to friends, and in nonfiction works like *The Cosmological Eye* and *The Books in My Life.* While Virginia Woolf believed that creativity required "a room of one's own," Henry Miller said he'd settle for a chair, and he charted how he wrote his work despite (or perhaps because of) leading a vagabond life in Paris, unattached to money and what it bought, yet free to practice his art.

For Henry Miller, writing was like "sewing up a wound," the wound inflicted by June's betrayal, which repeated a pattern of childhood betrayals—his life with a physically abusive mother and an alcoholic father and the sexual abuse of a trusted older man.

Lawrence Durrell, in *Art and Outrage,* described why he thought his friend Henry Miller used metaphors of healing in describing his writing. Durrell said that Miller retained a "large part of his childhood phantasy-life intact—with all its wounds." But Miller had "written it all out," providing himself and his readers, too, with "a catharsis." Through writing, Durrell said, Miller "cuts open the abscesses. . . . The pus and blood gushes out. But if any wound remains, it is clean, and can heal" and not continue to fester.

Writing, then, holds the key to how we all can achieve psychic growth, despite our pain and despair, and how we can imagine a hopeful future. Writing—organizing our thoughts, venting our feelings, and expressing ourselves in a complex way—Durrell thought, ultimately makes us hopeful, though the act of writing itself might cause us temporary pain.

Through writing, we change our relationship to trauma, for we gain confidence in ourselves and in our ability to handle life's difficulties. We come to feel that our lives are coherent rather than chaotic. We see ourselves as able to solve problems rather than as beset by problems. We enjoy a heightened sense of self. We become more optimistic. We recast our recovery from trauma as something we can accomplish rather than

seeing our ordeal as something to be passively borne. Writing supplants our feelings of hopelessness, helplessness, and victimization about a traumatic event.

When I was first writing about my recollections of the sexual abuse I had experienced as a girl, I used a metaphor similar to Henry Miller's. I believed that I was using my writing as a kind of scalpel to cut out the growth festering inside me—my story—which was making me sick. It was an instrument that I had to wield with great care and skill for the excision to be successful, for the wound to heal. Without telling my story, I thought, I would stay sick; I even might die.

This is how Henry Miller describes why writing is therapeutic: "The work which was begun as a refuge and escape from the terrors of reality leads the author back into life, not *adapted* to the reality . . . but *superior* to it. . . . He sees that it was not life but himself from which he had been fleeing. . . . The whole past life resumes its place in the balance and creates a vital, stable equilibrium which would never have resulted without the pain and the suffering. . . . [Writing] lifts the sufferer out of his obsessions and frees him for the rhythm and movement of life by joining him to the great universal stream in which we all have our being."

WHAT YOU CAN DO NOW You might begin a letter to someone, as Isabel Allende did. Can you transform it into a story, even a novel?

What were your earliest stories, essays, or poems like? Did you keep a diary? Do you have them? What do they tell you?

Can you recall some early, significant childhood memories? Can you write a sketch of your past? Be sure to read the "Caveat" in this chapter if you choose to do this.

Are there any significant losses in your life you feel compelled to write about? Can you begin writing or sketching the shape that a long work, or a life's work about this loss, might take?

Appendices: Information about MOVA
Legislator and Committee Lists
Victim-Related Internet Sites
Victim Assistance Resources
Maps of The World Trade Center

Massachusetts Office for Victim Assistance

1 Ashburton Place, Suite 1101
Boston, MA 02108
Phone: (617) 727-5200
Fax: (617) 727-6552
E-mail: MOVA@state.ma.us

MOVA's Mission

The Massachusetts Office for Victim Assistance is dedicated to assisting victims of crime through advocacy, legislation, public policy, grant administration, direct services, training, education and outreach. MOVA provides direct support to victims and their families through information, referrals and crisis counseling. MOVA represents the interests of crime victims while working in cooperation with other state agencies, victim service providers, the criminal justice system, the legislature and the federal government.

MOVA was established as an independent state agency in 1984 and is governed by the Victim and Witness Assistance Board. The agency oversees the implementation of the Massachusetts Victim Bill of Rights, monitors collections to the Victim and Witness Assistance Fund to increase funding for Victim and Witness Assistance programs, and offers other services pursuant to Massachusetts General Laws, Chapter 258B.

Victim Assistance

One of MOVA's most important goals is to provide direct services and support to crime victims across Massachusetts. Each year, MOVA receives hundreds of calls from crime victims and victim service providers seeking information, referrals and assistance for their particular needs. Many of the victims we serve are those whose perpetrators are unknown or out-of-state or whose cases have not yet been reported to law enforcement authorities.

Public Policy

Another arena in which MOVA plays an important role is in formulating and advocating for public policies to enhance the rights of crime victims and expand services to them. In recent years, MOVA has been instrumental in securing the passage of major victim rights reforms, including the Victim Rights Law of 1995. For the current legislative session MOVA has drafted and sponsored several critical initiatives, such as legislation to improve the collection of victim restitution, a constitutional amendment for victims of crime, and a bill to prevent convicted criminals from profiting from their crimes. Beyond legislation, MOVA works to shape public policy on victim rights and services by promoting administrative protocols and other regulatory efforts within state agencies that interact with crime victims.

Trainings and Community Education

MOVA serves as a resource for victims, victim advocates, victim service providers and criminal justice professionals throughout the state by providing publications, training, referrals and information. MOVA's publications include: *In the Aftermath of Crime: A Guide to Victim Rights and Services in Massachusetts*, brochures summarizing the *Massachusetts Bill of Rights* in several languages, and a comprehensive *Resource Directory for Crime Victim Assistance*. In addition, MOVA publishes a bi-monthly newsletter entitled *Victim Impact* that focuses on current issues facing crime victims. The agency also maintains a lending library of victim-related publications and videos, and serves as a clearinghouse for information on victim issues.

MOVA offers trainings throughout the year on victim rights, skill building, victim issues, victim services and the impact of crime for professionals who work with crime victims. Each year, MOVA organizes the Massachusetts Victim Rights Conference, a statewide gathering of crime victims, victim service providers and their supporters. This event draws nearly 1,000 participants to Boston for a day of reflection, education and inspiration.

VOCA: Funding for Victim Services

MOVA provides funding to non-profit agencies offering specialized victim services through its administration of the federal Victims of Crime Act (VOCA) victim assistance program in Massachusetts. Presently, 82 community-based programs receive VOCA funding to provide counseling and a variety of direct services to victims of domestic violence, child abuse, sexual assault, hate crimes and other crimes, surviving family members of homicide victims, children who witness violence, and communities impacted by crime.

SAFEPLAN Project

In 1995, the state legislature provided funds to launch SAFEPLAN Massachusetts, a court-based civil advocacy program that helps victims of domestic violence seeking protection from abuse. SAFEPLAN advocates assist victims of domestic violence plan for their safety and obtain protective orders. Advocates provide referrals to local support services, information on legal and safety options and court accompaniment. SAFEPLAN Advocates are located in the district and probate courts in Hampshire, Franklin, Plymouth, Worcester, Barnstable, Berkshire, Hampden and Bristol counties. SAFEPLAN advocates make referrals to the district attorney's office when a victim seeks assistance in the criminal courts.

Who Are We?

Victim and Witness Assistance Board
Attorney General, Tom Reilly, Chairman
Gerard D. Downing, Berkshire District Attorney
Mary Ellen Doyle, Public Member
Elizabeth Scheibel, Northwestern District Attorney
Evelyn Tobin, Public Member
The Victim and Witness Assistance Board meets bi-monthly in sessions open to the public.

MOVA Staff
Shelagh Moskow, Executive Director
Judy Norton Senfleben, Deputy Director
Paula Almeida, Director of Administration & Finance
Jessica Cruzatti-Flavius, Office Manager
Brooke Ely, Family Violence/SAFEPLAN Project Manager
Robert Fleck, Victim Program Specialist
Liam Lowney, Policy Analyst
Rhonda Matthews, Victim Services Coordinator
Larissa Matzek, Training Coordinator
Barbara Pryor, Community Education Coordinator
Jennifer Williams, Intern
Lynne Williams, VOCA Program Specialist
Vacancy, VOCA Program Manager

The Massachusetts Senate
2000

Senator's Name	Room#	Phone # (617) 722-
Antonini, Robert (D- Leominster)	109E	1230
Bernstein, Robert (D- Worcester)	218	1544
Berry, Frederick (D-Peabody)	09B	1410
Birmingham, Thomas (D-Chelsea)	332	1500
Brewer, Stephen (D-Barre)	312C	1540
Clancy, Edward (D-Lynn)	410	1350
Creedon, Robert (D-Brockton)	413C	1200
Creem, Cynthia Stone (D-Newton)	416B	1639
Durand, Robert (D-Marlborough)	109C	1120
Fargo, Susan (D-Lincoln)	413F	1572
Glodis, Guy (D-Worcester)	413B	1485
Havern, Robert (D-Arlington)	513	1432
Hedlund, Robert (R-Weymouth)	413E	1646
Jacques, Cheryl (D-Needham)	312D	1555
Jajuga, James (D-Methuen)	216	1604
Joyce, Brian (D-Milton)	413A	1643
Knapik, Michael (R-Westfield)	309	1415
Lees, Brian (R- East Longmeadow)	308	1291
Lynch, Stephen F. (D-Boston)	520	1150
Maganani, David (D-Framingham)	413A	1640
Melconian, Linda (D-Springfield)	320	1660
Montigny, Mark (D-New Bedford)	413D	1440
Moore, Richard (D-Uxbridge)	518	1420
Morrisey, Michael (D-Quincy)	213B	1494
Murray, Therese (D-Plymouth)	511C	1330
Norton, Thomas (D-Fall River)	333	1114
Nuciforo, Andrea, Jr. (D-Pittsfield)	323	1625
Pacheco, Marc (D-Taunton)	413B	1551
Panagiotakos, Steven (D-Lowell)	416B	1630
Rauschenbach, Henri (R-Brewster)	315	1570
Shannon, Charles (D-Winchester)	421	1578
Tarr, Bruce (R-Gloucester)	507	1600
Tisei, Richard (R-Wakefield)	313	1206
Tolman, Steven (D-Brighton)	424	1280
Tucker, Susan C. (D-Andover)	416A	1612
Travaglini, Robert (D-East Boston)	511B	1634
Walsh, Marian (D-Boston)	405	1348
Wilkerson, Dianne (D-Boston)	312H	1673

MEMBERS OF THE HOUSE OF REPRESENTATIVES

2000

All telephone numbers begin: 722-

CITY OR TOWN	NAME	ROOM	PHONE
	A		
Saugus	Angelo, Steven	33	2060
Concord	Atkins, Cory	236	2430
Barnstable	Atsalis, Demetrius J.	167	2692
Quincy	Ayers, Bruce J.	540	2090
	B		
Newton	Balser, Ruth B.	134	2400
Cambridge	Barrios, Jarrett T.	130	2130
Worcester	Binienda, John J.	540	2090
North Adams	Bosley, Daniel E.	472	2120
Methuen	Broadhurst, Arthur J.	163	2263
Wrentham	Brown, Scott P.	443	2460
	C		
New Bedford	Cabral, Antonio F. D.	26	2080
Mashpee	Caffyn, Nancy J.	443	2460
Beverly	Cahill, Michael P.	22	2140
Brockton	Canavan, Christine E.	26	2080
Wilbraham	Candaras, Gale D.	136	2396
Springfield	Caron, Paul E.	275	2676
Southbridge	Carron, Mark J.	33	2060
Winchester	Casey, Paul C.	473 B	2240
Worcester	Chandler, Harriette L.	130	2130
Holyoke	Chesky, Evelyn G.	237	2305
Somerville	Ciampa, Vincent P.	472	2120
Chelmsford	Cleven, Carol C.	167	2692
Everett	Connolly, Edward G.	167	2692
Fall River	Correia, Robert	122	2810
Brockton	Creedon, Geraldine	146	2575
Wakefield	Cresta, Brian M.	549 A	2491
	D		
West Springfield	DeFilippi, Walter A.	128	2100
Winthrop	DeLeo, Robert A.	20	2410
Plymouth	deMacedo, Viriato Manuel	443	2460
Boston	Demakis, Paul C.	443	2460
Haverhill	Dempsey, Brian S.	34	2320
Boston	DiMasi, Salvatore F.	481	2255
Boston	Donnelly, David T.	136	2396
Woburn	Donovan, Carol A.	473 B	2240
	F		
Taunton	Fagan, James H.	146	2575
Malden	Fallon, Christopher G.	136	2396
Lynn	Fennell, Robert F.	38	2470
Melrose	Festa, Michael E.	473 F	2210
Andover	Finegold, Barry R.	146	2575
Newburyport	Finnegan, Kevin L.	540	2090
Boston	Finneran, Thomas M.	356	2500
Boston	Fitzgerald, Kevin W.	527 A	2250
Easthampton	Flavin, Nancy	254	2220
Bridgewater	Flynn, David L.	155	2017
Boston	Fox, Gloria L.	167	2692
Worcester	Fresolo, John P.	33	2060
Auburn	Frost, Paul K.	540	2090
	G		
Canton	Galvin, William C.	238	2380
Holliston	Gardner, Barbara	370	2300
Dracut	Garry, Colleen M.	473 G	2040
Waltham	Gately, David F.	156	2235
Shrewsbury	Ganch, Ronald W.	124	2100
Yarmouth	George, Thomas N.	541 B	2487
Medford	Giglio, Anthony P.	172	2305
Fitchburg	Goguen, Emile J.	134	2400
Boston	Golden, Brian Paul	473 B	2240
Lowell	Golden, Thomas A., Jr.	146	2575
Harwich	Gomes, Shirley	156	2256
Billerica	Greene, William G., Jr.	42	2370
	H		
Westfield	Hahn, Cele	254	2220
Weymouth	Haley, Paul R.	243	2990
Westford	Hall, Geoffrey D.	34	2320
Groton	Hargraves, Robert S.	473 G	2070
Needham	Harkins, Lida E.	234	2070
Boston	Hart, John A., Jr.	477	2120
Ipswich	Hill, Bradford	443	2460
Sturbridge	Hillman, Reed V.	38	2470
Lee	Hodgkins, Christopher J.	542 B	2637
Boston	Honan, Kevin G.	185	2947
Foxborough	Hyland, Barbara C.	541 B	2976
Marshfield	Hynes, Frank M.	489	2017
	J		
Somerville	Jehlen, Patricia D.	275	2676
North Reading	Jones, Bradley H., Jr.	124	2100
	K		
Sharon	Kafka, Louis L.	237	2305
Watertown	Kapnelian, Rachel	254	2220

CITY OR TOWN	NAME	ROOM	PHONE
Lexington	Kaufman, Jay R.	489	2017
Southwick	Keenan, Daniel F.	236	2430
Dalton	Kelly, Shaun P.	473 B	2240
Brockton	Kennedy, Thomas P.	277	2012
Springfield	Keough, Jack	472	2120
Newton	Khan, Kay	22	2140
Gardner	Knuuttila, Brian	167	2692
New Bedford	Koczera, Robert M.	38	2470
Newton	Koutoujian, Peter J.	448	2582
Webster	Kujawski, Paul	167	2692
Worthington	Kulik, Stephen	279	2210
	L		
Pittsfield	Larkin, Peter J.	43	2030
Marlborough	LeDuc, Stephen P.	146	2575
Attleboro	Lepper, John A.	548	2803
Dedham	Lewis, Maryanne	171	2783
Natick	Linsky, David Paul	473 F	2210
Wellesley	Locke, John A.	136	2396
	M		
Boston	Malia, Elizabeth A.	540	2090
Quincy	Mariano, Ronald	254	2220
Hanson	Marini, Francis L.	124	2100
Arlington	Marzilli, J. James, Jr.	443	2460
Lynn	McGee, Thomas M.	39	2230
Worcester	McManus, William J., II	174	2960
Greenfield	Merrigan, John F.	38	2470
Wilmington	Miceli, James R.	448	2582
Burlington	Murphy, Charles A.	479	2430
Lowell	Murphy, Kevin J.	39	2230
Cohasset	Murray, Mary Jeanene	134	2400
	N		
Northampton	Nagle, William P., Jr.	343	2600
Lowell	Nangle, David M.	448	2582
Clinton	Naughton, Harold P., Jr.	136	2396
Hanover	Nyman, Robert J.	448	2582
	O		
Kingston	O'Brien, Thomas J.	33	2060
Chelsea	O'Flaherty, Eugene L.	479	2070
Boston	Owens-Hicks, Shirley	156	2256
	P		
Milford	Parente, Marie J.	134	2400
Belmont	Paulsen, Anne M.	22	2140
Worcester	Pedone, Vincent A.	540	2090
Marblehead	Petersen, Douglas W.	473 F	2210
Grafton	Peterson, George N., Jr.	541 B	2489
Ludlow	Petrolati, Thomas M.	242	2180
Boston	Petruccelli, Anthony	166	2900
North Attleborough	Poirier, Elizabeth	237	2305
Wayland	Pope, Susan W.	237	2305
Sandwich	Provost, Ruth W.	26	2080
	Q		
Dartmouth	Quinn, John F.	136	2396
	R		
Revere	Reinstein, Kathi-Anne	236	2430
Springfield	Rivera, Cheryl A.	540	2090
Westport	Rodrigues, Michael J.	43	2030
Longmeadow	Rogeness, Mary S.	124	2100
New Bedford	Rogers, George	167	2692
Norwood	Rogers, John H.	236	2430
Salem	Ruane, J. Michael	238	2380
Boston	Rushing, Byron	542 B	2637
	S		
Lawrence	Santiago, Jose L.	146	2575
Boston	Scaccia, Angelo M.	167	2692
Leominster	Simmons, Mary Jane	33	2060
Peabody	Slattery, John P.	472	2120
Danvers	Speliotis, Theodore C.	174	2960
West Newbury	Stanley, Harriett L.	238	2380
Framingham	Stasik, John H.	134	2400
Framingham	Stefanini, John A.	146	2575
Boston	St. Fleur, Marie P.	167	2692
Amherst	Story, Ellen	167	2692
Mattapoisett	Straus, William M.	163	2263
Fall River	Sullivan, David B.	443	2460
Braintree	Sullivan, Joseph C.	443	2460
Springfield	Swan, Benjamin	167	2692
Brookline	Sydney, Ronny M.	26	2080
	T		
Whitman	Teahan, Kathleen M.	130	2130
Milton	Timilty, Walter F.	166	2900
Quincy	Tobin, A. Stephen	166	2900
Cambridge	Toomey, Timothy J., Jr.	39	2230
North Andover	Torrisi, David M.	39	2230
Rehoboth	Travis, Philip	236	2430
Falmouth	Turkington, Eric	473 F	2210
Barre	Tuttle, David H.	549	2489
	V		
Franklin	Vallee, James E.	42	2370
Gloucester	Verga, Anthony J.	134	2400
	W		
Chicopee	Wagner, Joseph F.	236	2430
Stow	Walrath, Patricia A.	466	2017
Boston	Walsh, Martin J.	527 A	2188
Cambridge	Wolf, Alice K.	473 G	2070

Victim-Related Internet Sites

GENERAL INFORMATION RESOURCES

National Criminal Justice Reference Service/Justice Information Center
www.ncjrs.org
National Organization for Victim Assistance
www.try~nova.org/
National Victim Center
www.nvc.org
Office for Victims of Crime
www.ojp.usdoj.gov/ovc/
Massachusetts Office for Victim Assistance
www.state.ma.us/mwa
Join Together
www.jointogether.org
Victim Assistance Online
www.vaonline.org

CHILD ABUSE

American Bar Association Center on Children and the Law
www.abanet.org/child/
American Professional Society on the Abuse of Children child.cornell.edu/APSAC/apsac.home.html
Child Abuse Prevention Network
www.child.cornell.edu
National Children's Advocacy Center
www.ncac~hsv.org/
National Clearinghouse on Child Abuse & Neglect Information
www.calib.com/nccanch

DOMESTIC AND FAMILY VIOLENCE

Domestic Abuse Page of the Nashville Police Department
www.nashville.net/~police/abuse/index.html
Family Violence Prevention Fund
www.igc.org/fund/
Minnesota Higher Education Center Against Violence and Abuse
www.mincava.umn.edu
National Coalition Against Domestic Violence
www.webmerchants.com/ncadv/default.htm
National Domestic Violence Hotline
www.usdoj.gov/vawo/newhotline.htm
Violence Against Women Office (U.S. Department of Justice)
www.usdoj.gov/vawo/

DRUNK DRIVING

MADD
www.madd.org
MADD (Bristol County)
www.ultranet.comforward/~Toniasue

FRAUD

National Fraud Information Center
www.fraud.org
National Insurance Crime Bureau
www.nicb.org
Federal World Government
www.fedworld.gov
U.S. Postal Inspection Service
www.usps.gov/websites/depart/inspect/consmenu.htm

MISSING CHILDREN

Childquest International
www.childquest.org/
National Center for Missing and Exploited Children
www.missingkids.org

RAPE AND SEXUAL ABUSE

National Coalition Against Sexual Assault
www.ncasa.org
Rape Abuse and Incest National Network
www.rainn.org
Sexual Assault Information Page
www.cs.utk.edu/~bartley/saInfoPage.html

SURVIVOR RESOURCES & NATIONAL AND STATE HOMICIDE ORGANIZATIONS

David Baldwin's Trauma Information Page
www.trauma-pages.com
Parents of Murdered Children
www.pomc.com
MADD
www.madd.org
COPS
www.nationalcops.org/npw.htm
New Mexico Survivors of Homicide
www.nmsoh.org/index.html
Justice for All
www.jfa.net
Victim's Page
www.eskimo.com/~yaquii/victimpg.htm
The Fallen Wall
www.fallenwall.org

Victim Assistance Resources

Statewide Victim Assistance Agencies:	
Massachusetts Office for Victim Assistance	(617) 727-5200
Victim Compensation Division, Attorney General's Office	(617) 727-2200
Criminal History Systems Board, Victim Service Unit	(617) 660-4690
Department of Correction, Victim Service Unit	(617) 727-8612
Parole Board, Victim Service Unit	(617) 727-3271
U.S. Attorney's Office, Victim Witness Assistance	(617) 223-9400
Statewide Hotlines and Referral Centers:	
Child Abuse & Neglect Hotline	(800) 792-5200
Domestic Violence Hotline - *Call 411 to be connected to a local shelter*	DIAL 411
Elder Abuse & Neglect Hotline	(800) 922-2275
Lawyer Referral	(800) 392-6164
Massachusetts Alcohol and Drug Referral Hotline	(800) 327-5050
Parents Anonymous of Massachusetts	(800) 882-1250
Parental Stress Line	(800) 632-8188
Samaritans Suicide Prevention Hotline	(617) 247-8050
Samariteens	(800) 252-8336
District Attorney Victim and Witness Programs:	
Berkshire County - Elizabeth Keegan , Director	(413) 443-3500
Bristol County - Michele Stanton, Director	(508) 997-0711
Cape and Islands District - Virginia Bein, Director	(508) 362-8103
Essex County - Michaelene McCann, Director	(978) 745-6610
Hampden County - Maria Rodriguez, Director	(413) 747-1038
Middlesex County – Patrice Provitola, Director	(617) 494-4604
Norfolk County – Rai Cunningham, Director	(781) 329-5440
Northwestern District - Susan Manatt, Director	(413) 586-5780
Plymouth County - Michelle Mawn, Director	(508) 584-8120
Suffolk County - Janet Fine, Director	(617) 210-8800
Worcester County - Tony Pellegrini, Director	(508) 792-0214
Drunk Driving - MADD Chapters:	
MADD Statewide Victim Hotline	(800) 633-6233
MADD State Office	(508) 875-3736
MADD Berkshire County Chapter	(913) 663-3339
MADD Bristol County Chapter	(508) 997-8364
MADD Cape Cod Chapter	(508) 420-0200
MADD Hampden County Chapter	(413) 592-9953
MADD Metro West Chapter	(508) 875-3736
MADD Plymouth County Chapter	(978) 585-1888
MADD Worcester County Chapter	(508) 831-9785

Family Violence Services:

Alternative House - *Lowell*	(978) 454-1436
ARCH - *Springfield*	(413) 733-7100
Asian Shelter and Advocacy Project- *Boston*	(617) 338-2350
Casa Myrna Vasquez - *Boston*	(617) 521-0100
Daybreak - *Worcester*	(508) 755-9030
Domestic Violence Ended (DOVE) - *Quincy*	(617) 471-1234
Elizabeth Stone House -*Plain Jamaica*	(617) 522-3417
F.I.N.E.X. House - *Dorchester*	(617) 288-1054
Fenway Community Health Center (Gay/Lesbian Services) - *Boston*	(617) 267-0900
Mary Foreman House - *Dorchester*	(800) 992-2600
Harbor Me - *Chelsea*	(617) 889-2111
Help for Abused Women and Their Children (HAWC) - *Salem*	(508) 744-6841
Independence House - *Hyannis*	(800) 439-6507
International Institute - *Boston*	(617) 536-1081
N.E.L.C.W.I.T. - *Greenfield*	(413) 772-0806
Necessities/Necessidades - *Northhampton*	(413) 586-5066
Network for Battered Lesbians - *Boston*	(617) 424-8611
New Bedford Women's Center Battered Women Project - *New Bedford*	(508) 992-4222
New Beginnings - *Westfield*	(413) 562-1920
New Hope -*Attleboro, Norwood, Taunton*	(800) 323-4673
Our Sister's Place - *Fall River*	(508) 677-0224
Renewal House - *Roxbury*	(617) 566-6881
Respond - *Somerville*	(617) 623-5900
Safe Place, Inc. - *Nantucket*	(508) 228-2111
Services Against Family Violence - *Malden*	(781) 324-2221
South Shore Women's Center - *Plymouth*	(508) 746-2664
Transition House - *Cambridge*	(781) 661-7203
Waltham Battered Women's Support Committee - *Waltham*	(617) 899-8676
Womanshelter/Companeras - *Holyoke*	(413) 536-1628
Womansplace - *Brockton*	(508) 588-2041
Women's Crisis Center - *Newburyport*	(978) 465-2155
Women's Protective Services - *Framingham*	(508) 626-8686
Women's Resource Center - *Lawrence*	(978) 685-2480
Women's Resource Center - *Haverhill*	(978) 373-4041
Women's Resources - *Fitchburg*	(978) 342-9355
Women's Service Center - *Pittsfield*	(413) 443-0089
Women's Service Center - *North Adams*	(413) 663-9709
Women's Support Services - *Vineyard Haven*	(508) 696-7233

Homicide Bereavement Services:

After Homicide Program - *Worcester*	(508) 791-3261
Family Bereavement Program - *Marlborough*	(508) 481-8290
Homicide Bereavement Program - *Greenfield*	(413) 774-7931
Living After Murder Program - *Roxbury*	(617) 541-3790

Omega Emotional Support Services - *Somerville*	(617) 776-6369
Project Reach - *New Bedford and Plymouth*	(508) 996-3147
Surviving After Murder Program - *Springfield*	(413) 732-7419
Trauma Clinic - *Boston*	(617) 731-3200
Victims of Crime and Loss Program (VOCAL) - *Beverly*	(508) 927-4506
Victims of Violence Program - *Cambridge*	(617) 498-1284

<u>Sexual Assault Services</u>:

ARCH - YMCA - *Springfield*	(413) 733-7100
Beth Israel Hospital Rape Crisis Service - *Boston*	(617) 667-4645
Blackstone Valley Rape Crisis Team - *Milford*	(508) 478-2992
Boston Area Rape Crisis Center - *Cambridge*	(617) 492-7273
Cape Ann Sexual Assault Crisis Service - *Gloucester*	(978) 281-7631
Cape Cod Rape Crisis Center - *Hyannis*	(508) 790-1344
Community Programs Against Sexual Abuse - *Roxbury*	(617) 442-6300
Everyone's Center - *Amherst*	(413) 545-0800
Rape Crisis Center - *Marlborough*	(508) 485-7273
Latinas Against Sexual Assault - *Lawrence*	(978) 685-2480
Massachusetts General Hospital Rape Emergency Unit - *Boston*	(617) 726-2000
N.E.L.C.W.I.T - *Greenfield*	(413) 772-0806
New Hope Sexual Assault Program - *Attleboro*	(800) 323-4673
Norfolk County Sexual Assault Unit - *Dedham*	(781) 326-1111
North Shore Rape Crisis Center - *Beverly*	(800) 922-8772
Women's Place Crisis Center - *Brockton*	(508) 588-8255
Project Rap Crisis Team - *Beverly*	(800) 922-8772
Rape Crisis Center of Berkshire County - *Pittsfield*	(413) 499-2425
Rape Crisis Program of Central Massachusetts - *Worcester*	(508) 799-5700
Rape Crisis Service of Greater Lowell - *Lowell*	(800) 542-5212
Women's Protective Services - *Framingham*	(508) 626-8686

<u>Massachusetts Victim/Citizen Advocacy and Support Groups:</u>

Charlestown After Murder Program (CHAMP)	(781) 848-8973
Citizens for Safety	(617) 542-7712
Clothesline Project	(508) 385-7004
Joey Fournier Victim Services	(978) 837-5474
Massachusetts Citizens to Prevent Handgun Violence	(617) 437-9384
Mothers Against Drunk Driving	(800) 438-6233
Peace at Home	(617) 482-9497

<u>Statewide Research and/or Advocacy Organizations:</u>

Boston Coalition	(617) 451-1441
Children's Law Center of Massachusetts	(781) 581-1977
Civil Liberties Union of Massachusetts (CLUM)	(617) 482-3170
Crime and Justice Foundation	(617) 426-9800
Education Development Center	(617) 969-7100

Flaschner Judicial Institute	(617) 542-8838
Jane Doe, Inc.	(617) 248-0922
Massachusetts Law Reform Institute	(617) 357-0700
Massachusetts Society for the Prevention of Cruelty to Children	(617) 587-1500
National Organization for Women - Massachusetts	(617) 232-1017

<u>State Agency Resources:</u>

Administrative Offices of the Trial Court	(617) 742-8575
AIDS/HIV Bureau (DPH)	(617) 624-5300
Attorney General's Office	(617) 727-2200
Board of Bar Overseers	(617) 357-1860
Child Support Enforcement Division	(617) 577-7200
Citizen Information Service	(617) 727-7030
Committee for Public Counsel Services	(617) 482-6212
Corrections Department (DOC)	(617) 727-3300
Criminal History Systems Board	(617) 660-4690
Criminal Justice Training Council	(617) 727-7827
Disabled Persons Protection Commission	(617) 727-6465
District Court Administrative Office	(978) 745-9010
Elder Affairs, Executive Office	(617) 727-7750
Family Violence and Sexual Abuse Resources	(617) 624-5070
Governor's Alliance Against Drugs	(617) 727-0786
Governor's Hate Crimes Task Force	(617) 727-6300
Governor's Highway Safety Bureau	(617) 727-5073
Governor's Office	(617) 727-3600
Governor's Office of Constituent Services	(617) 727-6250
Judicial Conduct Commission	(617) 725-8050
Judicial Institute	(617) 742-8383
Juvenile Court Administrative Office	(617) 367-5767
Massachusetts Commission Against Discrimination: Eastern	(617) 727-3990
Massachusetts Commission Against Discrimination: Western	(413) 739-2145
Massachusetts Legal Assistance Corporation	(617) 367-8544
Massachusetts Office for Children	(617) 727-8900
Massachusetts Office for Victim Assistance	(617) 727-5200
Massachusetts Office on Disability	(617) 727-7440
Massachusetts State Police	(508) 820-2300
Mental Health Department (DMH)	(617) 727-5500
Parole Board	(617) 727-3271
Patient Abuse Advisory Office	(800) 462-5540
Probate and Family Court Administrative Office	(617) 742-9743
Probation, Office of the Commissioner	(617) 727-5300
Public Health Department (DPH)	(617) 624-6000
Public Safety, Executive Office	(617) 727-7775
Refugees and Immigrants Office	(617) 727-7888
Social Services Department (DSS)	(617) 727-0900

Superior Court Administrative Office	(617) 725-8130
Supreme Judicial Court	(617) 557-1000
Transitional Assistance Department (DTA)	(617) 348-8500
Victim Compensation and Assistance Division	(617) 727-2200
Violence Prevention Office (DPH)	(617) 624-5070
Youth Services Department (DYS)	(617) 727-7575

Massachusetts Professional Organizations:

Massachusetts Bar Association	(617) 542-3602
Massachusetts Chiefs of Police Association	(617) 723-5002
Massachusetts District Attorneys Association	(617) 723-0642
Massachusetts Medical Society	(781) 893-4610
Massachusetts Psychological Association	(617) 523-6320
Massachusetts Sheriffs Association	(617) 635-1100
Women's Bar Association of Massachusetts	(617) 695-1851
Women's Legislative Caucus	(617) 722-2800

Massachusetts State Correctional Facilities:

Bay State Correctional Center	(617) 727-8474
Boston State Pre-Release Center	(617) 727-8130
Bridgewater State Hospital	(508) 697-8161
Lancaster Pre-Release Center	(978) 368-8388
MCI Cedar Junction/Walpole	(508) 668-4730
MCI Concord	(617) 727-1950
MCI Framingham	(617) 727-5056
MCI Lancaster	(508) 792-7590
MCI Norfolk	(508) 668-0800
MCI Plymouth	(617) 727-8938
MCI Shirley	(978) 425-4341
Northcentral Correctional Institution	(508) 792-7560
Northeastern Correctional Center	(978) 369-4120
Old Colony Correctional Center	(508) 697-3360
Park Drive Pre-Release Center	(617) 727-2275
Pondville Correctional Center	(617) 727-5203
Southeast Correctional Center	(508) 727-7672
South Middlesex Correctional Center	(508) 872-0281

County Jails and Houses of Correction Facilities:

Barnstable County Jail and House of Correction	(508) 362-3252
Berkshire County Jail and house of Correction	(413) 443-7220
Bristol County Jail and House of Correction	(508) 995-6400
Dukes County House of Correction	(508) 627-5173
Franklin County Jail and House of Correction	(413) 774-4014
Hampden County Jail and House of Correction	(413) 547-8000
Hampshire County Jail and House of Correction	(413) 584-5911

National Association of Social Workers	(202) 408-8600
National Association of Women Judges	(757) 259-1841
National Association of Women Lawyers	(312) 988-6186

<u>National Research and/or Advocacy Organizations:</u>

American Association on Retired Persons	(202) 434-2277
American Indian Law Center	(505) 277-5462
American Prosecutors Research Institute	(703) 549-4253
Amnesty International	(212) 807-8400
Anti-Defamation League	(212) 490-2525
Battered Women's Justice Project	(800) 903-0111
Campus Violence Prevention Center	(410) 830-2178
Center for Constitutional Rights	(212) 614-6464
Center for Law and Justice	(206) 685-2043
Center for the Prevention and Control of Interpersonal Violence	(313) 577-6690
Center for the Prevention of Sexual and Domestic Violence	(206) 634-1903
Center for the Study and Prevention of Violence	(303) 492-1032
Center for the Study of Crime Victims' Rights, Remedies & Resources	(203) 932-7041
Center for Women Policy Studies	(202) 872-1770
Center to Prevent Handgun Violence	(202) 289-7319
Child Abuse and Neglect Clearinghouse	(202) 394-3366
Children's Defense Fund	(202) 628-8787
Family Violence Prevention Fund	(415) 252-8900
Foundation for the Prevention of Child Abuse	(419) 535-3232
Handgun Control, Inc.	(202) 898-0792
Health Resource Center on Domestic Violence	(888) 792-2873
National Center for Missing and Exploited Children	(800) 843-5678
National Center for Prosecution of Child Abuse	(703) 739-0321
National Center for Victims of Crime	(703) 276-2880
National Center on Elder Abuse	(202) 682-0100
National Center on Women and Family Law	(212) 219-1800
National Children's Advocacy Center	(205) 533-0531
National Committee for the Prevention of Child Abuse	(312) 663-3520
National Committee for the Prevention of Elder Abuse	(508) 793-6166
National Crime Prevention Council	(202) 466-6272
National Crime Victims Research and Treatment Center	(803) 792-2945
National Gay and Lesbian Task Force	(202) 332-6483
National Indian Justice Center	(707) 762-8113
National Law Enforcement Council	(202) 835-8020
National Organization for Women	(202) 331-0066
National Organization of Victim Assistance	(202) 232-6682
National Resource Center on Domestic Violence	(800) 537-2238
National School Safety Center	(805) 373-9977
NOW Legal Defense and Education Fund	(212) 925-6635
Parents of Murdered Children	(513) 721-5683

Essex County Jail and House of Correction	(508) 750-1900
Middlesex County House of Correction	(508) 667-1711
Middlesex County Jail	(617) 494-4400
Norfolk County Jail and House of Correction	(617) 329-3705
Plymouth County Jail and House of Correction	(508) 830-6200
Suffolk County House of Correction	(617) 635-1000
Worcester County Jail and House of Correction	(508) 854-1800

Federal Agency Resources:

Bureau of Alcohol, Tobacco, and Firearms: Boston	(617) 565-7040
Bureau of Justice Statistics Clearinghouse	(800) 732-3277
Bureau of Justice Statistics Response Center	(800) 421-6770
Centers for Disease Control and Prevention	(404) 639-3311
Child Abuse and Neglect Clearinghouse	(800) 394-3366
Drug Enforcement Administration: Boston	(617) 557-2100
Drug Information Policy Clearinghouse	(800) 666-3332
Federal Bureau of Investigation: Boston	(617) 742-5533
Institute of Justice Clearinghouse	(800) 851-3420
Juvenile Justice Clearinghouse	(800) 638-8736
National Center for Injury Prevention and Control	(770) 488-4696
National Clearinghouse for Alcohol and Drug Information	(800) 729-6686
U.S. Attorneys Office: Boston	(617) 223-9400
U.S. Department of Justice	(202) 514-2000
U.S. Office for Victims of Crime	(202) 307-5983
U.S. Office of Juvenile Justice and Delinquency	(202) 307-0751
U.S. Office on Violence Against Women	(202) 616-8894
Violence and Traumatic Stress Research Branch	(301) 443-3728

National Professional Organizations:

American Bar Association	(202) 662-1000
American Correctional Association	(612) 928-4658
American Counseling Association	(703) 823-9800
American Probation and Parole Association	(606) 244-8207
American Professional Society on the Abuse of Children	(312) 554-0166
American Psychiatric Association	(202) 682-6000
American Psychological Association	(202) 336-5500
American Public Health Association	(202) 789-5600
Association of Paroling Authorities: Victims Committee	(916) 354-1781
Coalition of Victim's Attorneys and Consultants	(703) 276-2880
National Association of Attorneys General	(202) 326-6000
National Association of Crime Victim Compensation Boards	(703) 370-2996
National Criminal Justice Association	(202) 624-1440
National District Attorneys Association	(703) 549-9222
National Governors' Association	(202) 624-5300
National Sheriffs Association	(800) 424-7827

Remove Intoxicated Drivers USA	(518) 393-4357
Resource Center on Child Protection and Custody	(800) 527-3223
Security on Campus, Inc.	(610) 768-9330
State Justice Institute	(703) 684-6100
Victim's Assistance and Legal Organization (VALOR)	(703) 684-8310
Victims CAN (Constitutional Amendment Network)	(703) 276-2880
Victim Offender Mediation Association	(714) 836-8100
Violence Policy Center	(202) 822-8200
Women's Legal Defense Fund, Inc.	(202) 986-2600

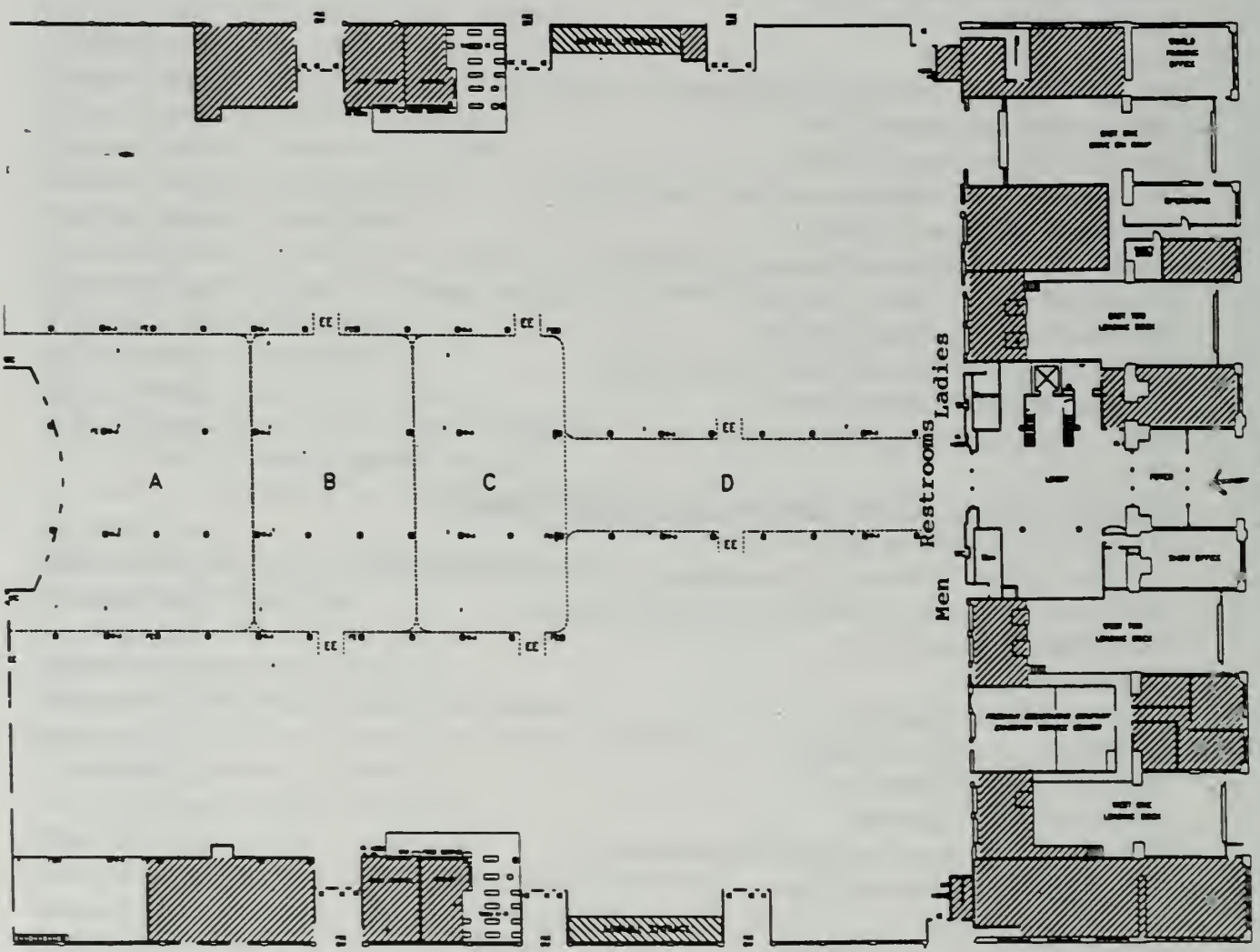
National Hotlines and Referral Centers:

AIDS/HIV Information Hotline	(800) 342-2437
Child Help USA	(800) 422-4453
Drug Abuse Hotline	(800) 662-4357
Family Violence Prevention Fund Information Line	(888) 792-2873
Marital Rape Information Line	(217) 244-1024
Mothers Against Drunk Driving	(800) 438-6233
National Center for Missing and Exploited Children	(800) 843-5678
National Child Abuse Hotline	(800) 422-4453
National Criminal Justice Referral Center	(800) 851-3420
National Family Violence Helpline	(800) 222-2000
National Self-Help Clearinghouse	(212) 642-2944
National Sexually Transmitted Diseases Hotline	(800) 227-8922
National Victim Resource Center	(800) 627-6872
Rape, Abuse, and Incest National Network	(800) 656-4673

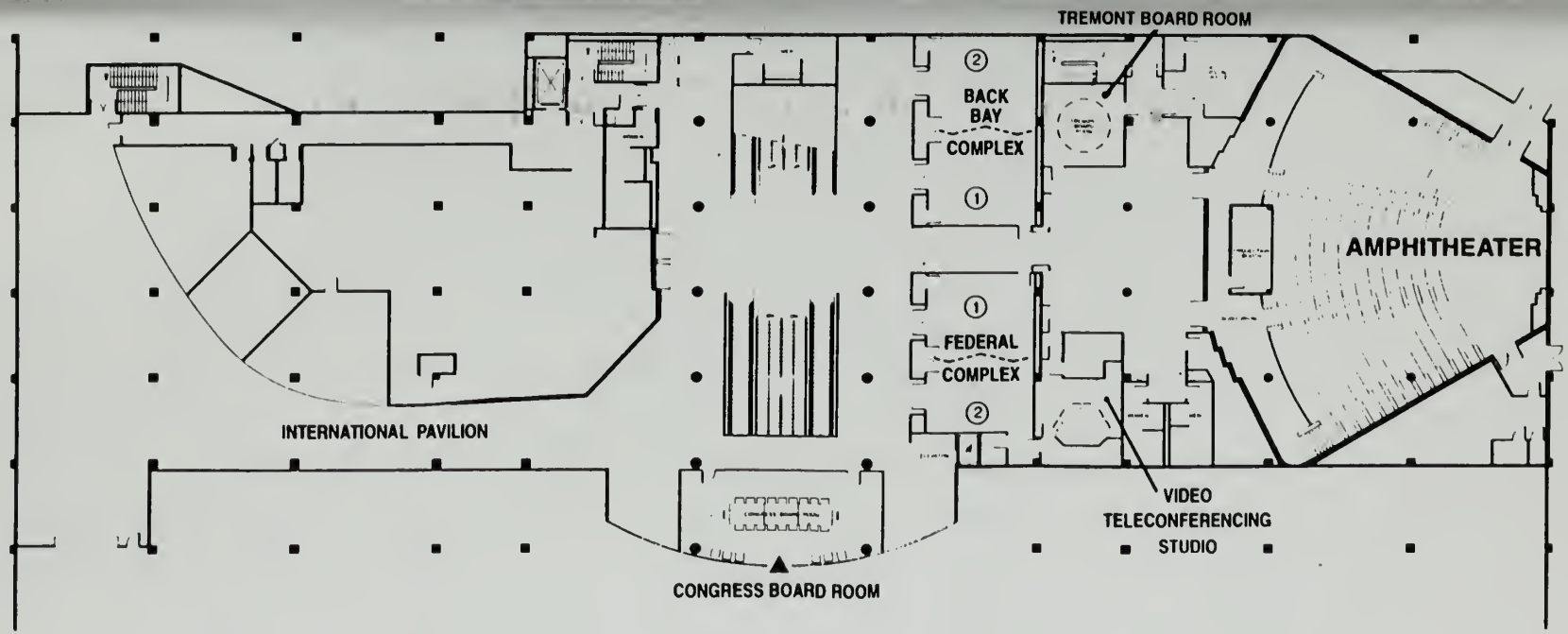
National Victim/Citizen Advocacy and Support Groups:

Alliance Against Intoxicated Motorists	(708) 240-0027
Alliance Against Violence in Entertainment for Children	(508) 481-6926
One Voice/American Coalition for Abuse Awareness	(202) 462-4688
Child Find of America, Inc.	(914) 255-1848
Child Help USA	(540) 399-1926
Children's Safety Network	(301) 443-0926
Coalition to Stop Gun Violence	(202) 530-0340
Compassionate Friends, Inc.	(630) 990-0010
Cult Awareness Network	(773) 267-7777
Incest Survivors Resource Network International	(505) 521-4260
Missing Kids International, Inc.	(703) 761-2456
Men Stopping Rape	(608) 257-4444
Mothers Against Drunk Driving	(800) 438-6233
National Coalition Against Domestic Violence	(800) 799-7233
National Coalition Against Pornography	(513) 521-6227
Neighbors Who Care	(703) 904-7311

COMMONWEALTH HALL



WORLD TRADE CENTER
BOSTON


TREMONT BOARD ROOM
BACK BAY COMPLEX
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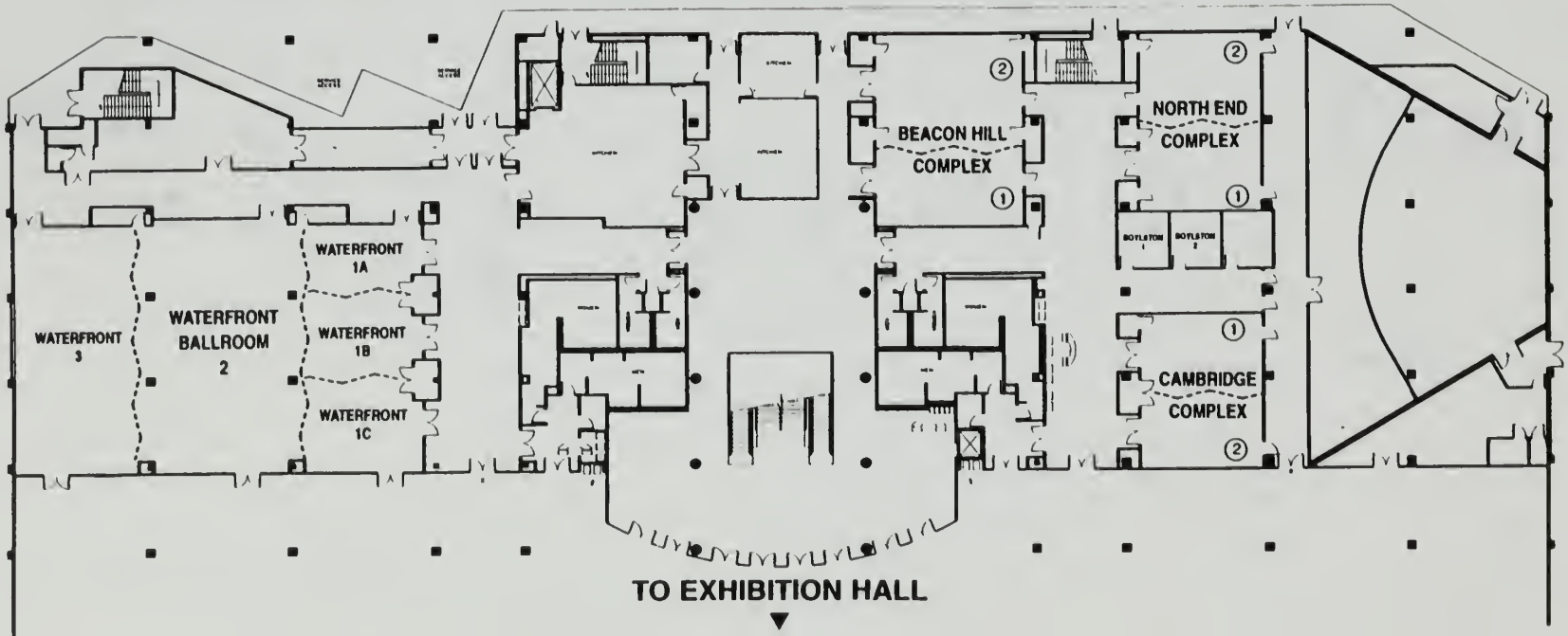
FEDERAL COMPLEX
INTERNATIONAL PAVILION
VIDEO TELECONFERENCING STUDIO
CONGRESS BOARD ROOM

LOWER LEVEL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NORTH END COMPLEX
CAMBRIDGE COMPLEX
BOYLSTON 1
BOYLSTON 2
WATERFRONT 1A
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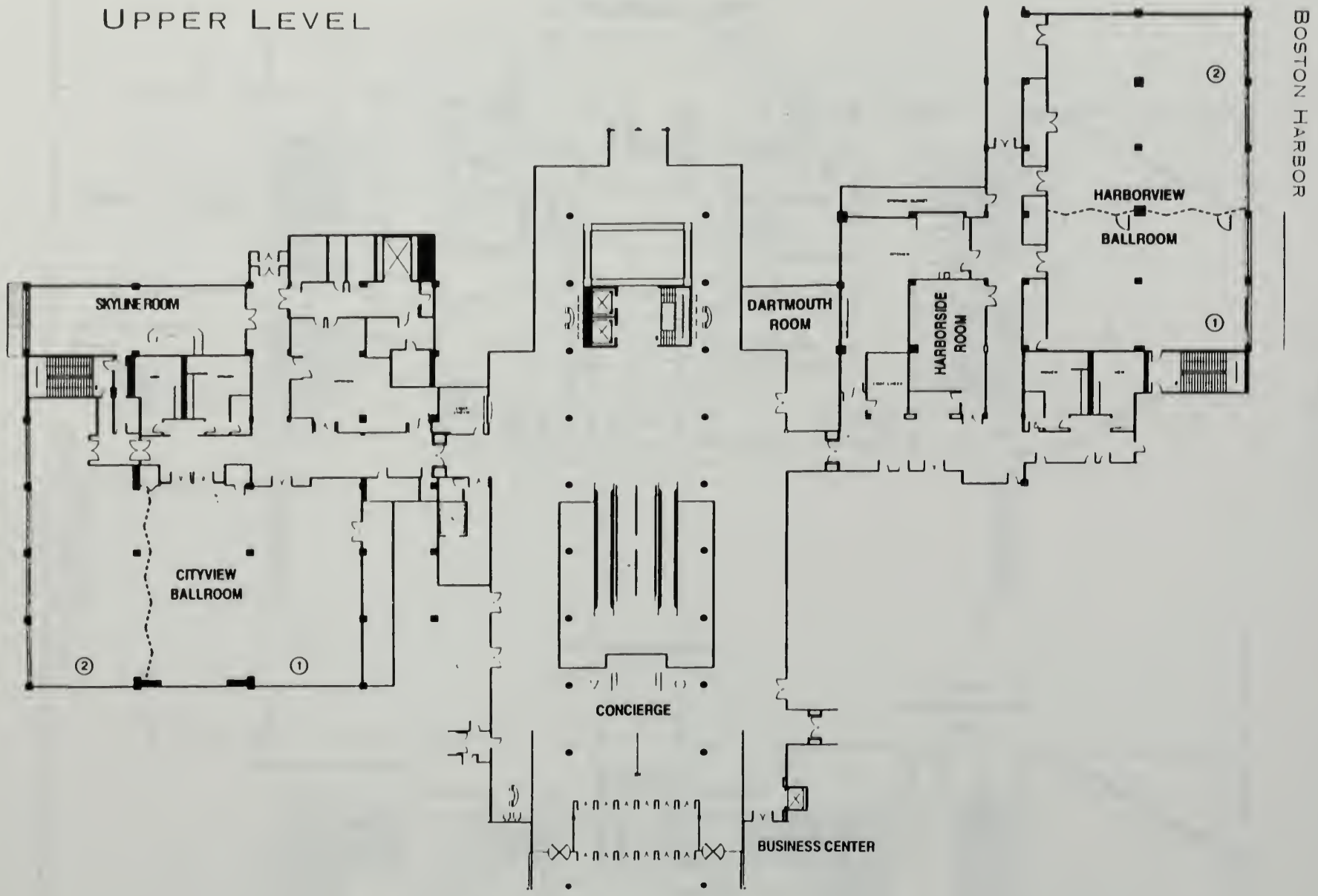
WATERFRONT 1C
WATERFRONT 2 BALLROOM
WATERFRONT 3
TO EXHIBITION HALL

UPPER LEVEL


BOSTON HARBOR
SKYLINE ROOM
CITYVIEW BALLROOM
DARTMOUTH ROOM
HARBORSIDE ROOM
HARBORVIEW BALLROOM
CONCIERGE
BUSINESS CENTER
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